ELECTRONIC HEALTH RECORDS SYSTEM

Super User Manual

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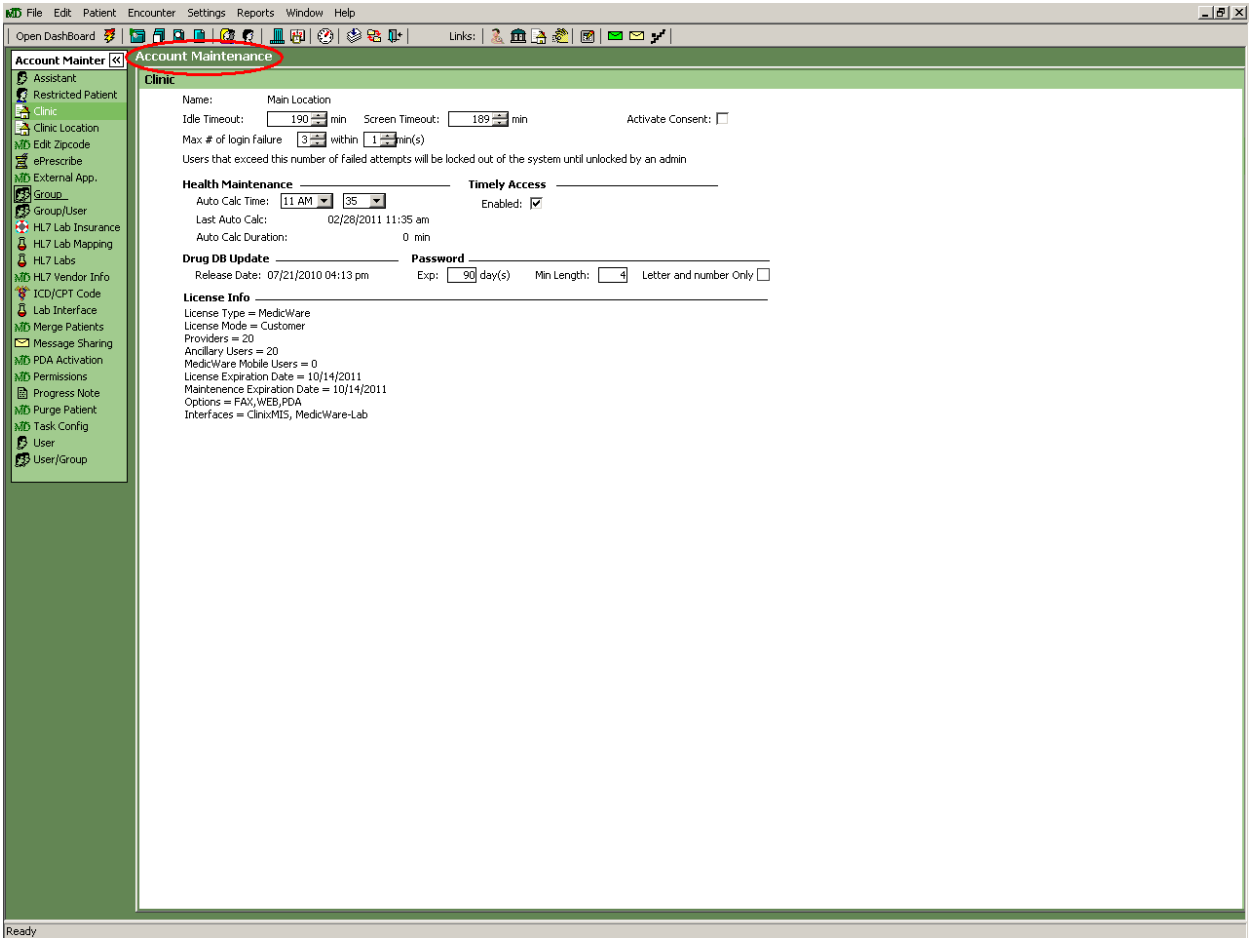
ACCOUNT MAINTENANCE

The Account Maintenance menu contains the primary tabs necessary to set up users, establish system permissions and other clinic-defined elements.



The following Account Maintenance tabs are listed in the order suggested for setting up the clinic. They can, however, be rearranged to suit your needs. The items discussed in this section are:

1. Clinic
2. Clinic Location
3. Adding a Clinic Location
4. User
5. Group
6. Adding a Group
7. User/Group
8. Group/User
9. Permissions
10. Tab Sequencing
11. Progress Note: Sequence and Descriptions
12. ICD/CPT Code
13. Message Sharing
14. E-Prescribe
15. Edit Zipcode
16. Merge Patients
17. External App.
18. Restricted Patient

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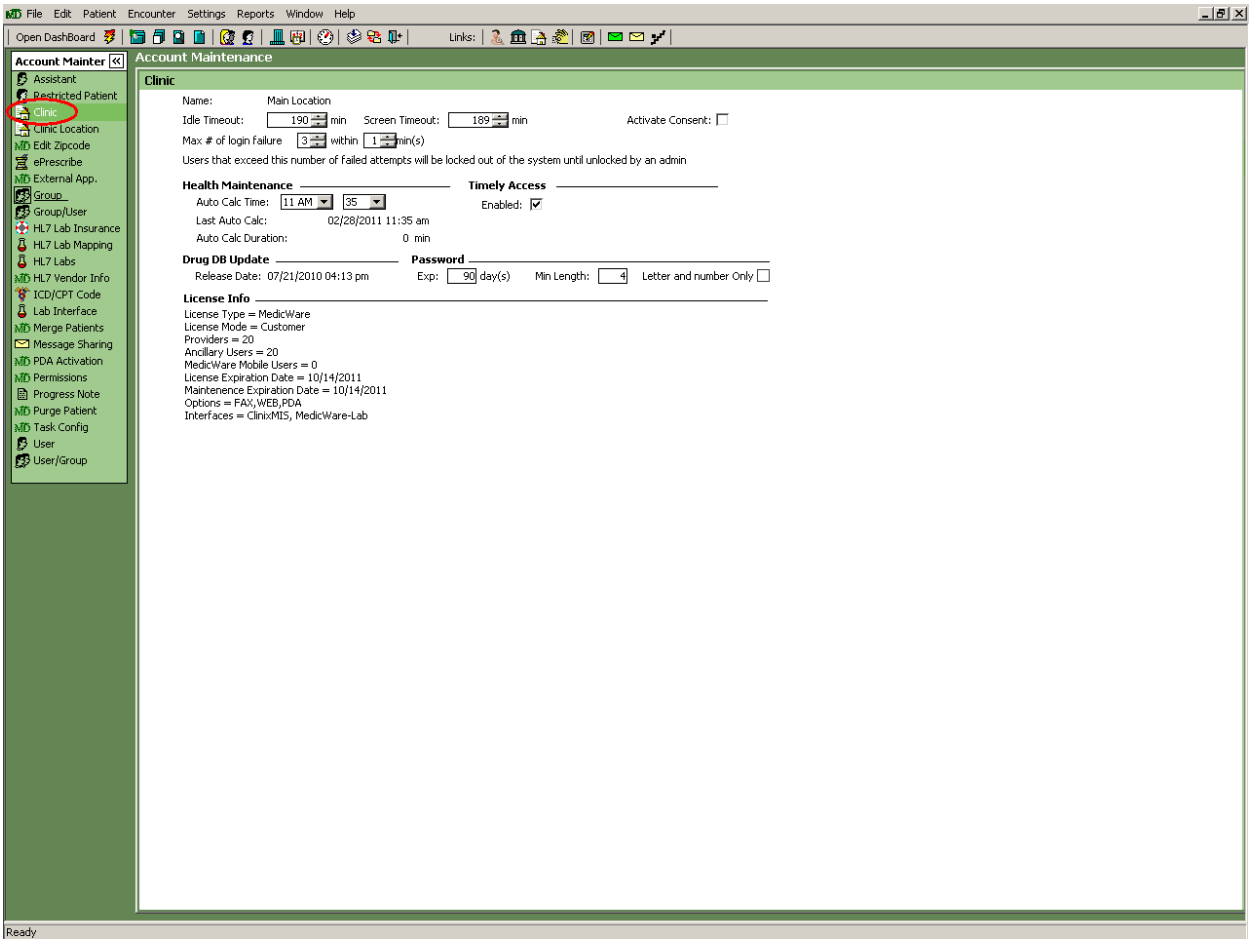
1. CLINIC

The ‘Clinic’ tab is for establishing inactivity/screen time-periods, the health maintenance auto-calculation time each day, the default password expiration period (passwords are established in the ‘User’ tab), password rules (i.e. minimum password length and forced requirement of letters and numbers) and also to turn on the “Timely Access” feature in the database.

This information is set during implementation; however, it can be changed at any time, depending on your clinic’s needs.

The “Timely Access” feature must be activated in your database if you wish to provide your patients with on-line access to their health information (such as lab results, medication list, problem list). Once it is turned-on in the ‘Clinic’ tab, it must then be turned on for each patient, on request, in their ‘Demographics’ tab in the Patient Information area.



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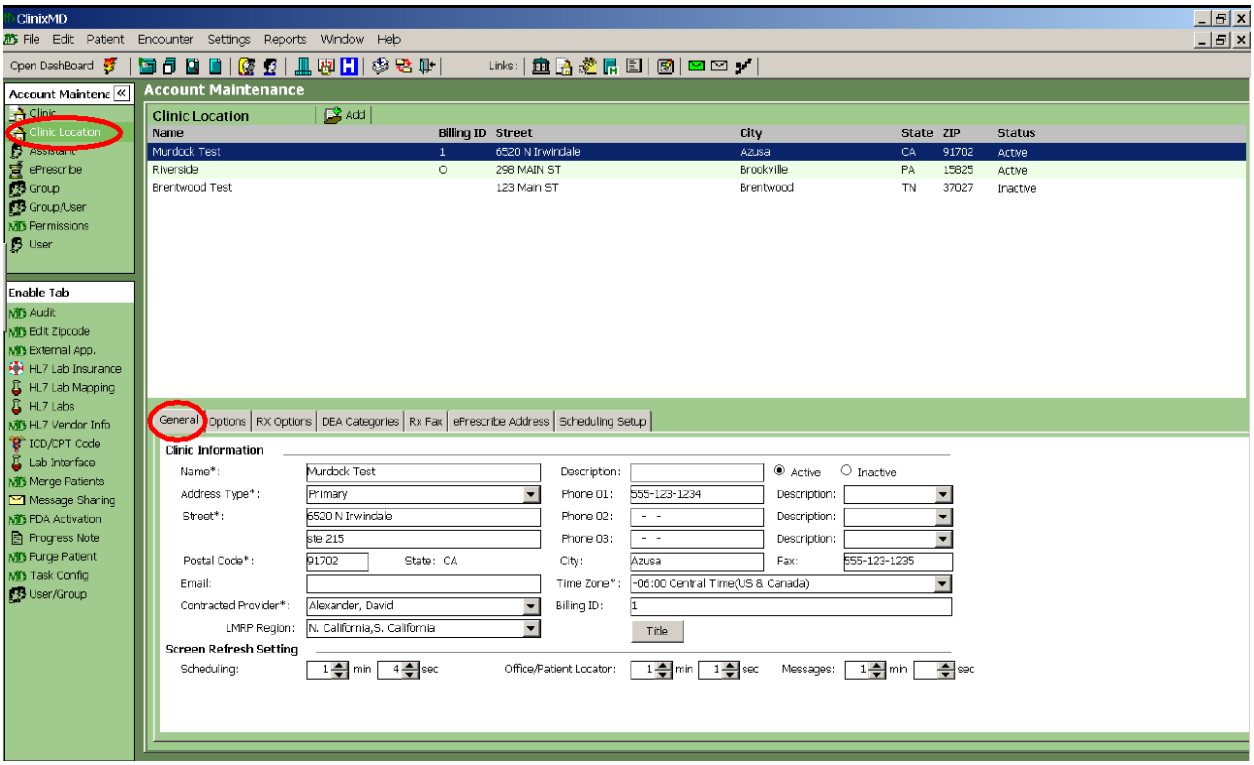
2. CLINIC LOCATION

The 'Clinic Location' window is used to maintain contact information for each location that makes up the clinic. This window is divided into two panes, List and Details. The List pane shows a single line-item view of the clinic information. The Details pane, on the lower portion of the window, shows a more comprehensive view

A. General



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- **Name** (required) – Used to identify the name of the associated clinic location.
- **Address Type** (required) – A drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The user is then asked to fill in the necessary postal code information to update the database.
- **State –** This field is automatically populated based on the Postal Code entered.
- **Email** – Used to enter email addresses for clinic locations.
- **Contracted Provider** – This drop-down box is used to select the Physician who is listed as the contract provider for billing insurance companies.
- **LMRP Region**- State in which the practice resides
- **Description** – Available to add further details about the location.
- **Code –** (required) A three character alpha-numeric field used to uniquely identify a location.
- **Phone 1-3 with Descriptions –** Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.
- **City –** This field is automatically populated based on the Postal Code entered.
- **Fax –** Used to enter the fax number for a location.
- **Time Zone –** This drop-down box is used to select the appropriate Time Zone for the location.
- **Billing ID –** This field is used to enter the billing ID. This field is typically used for billing interfaces.
- **Title** – This button allows you to customize the heading information for faxed/printed prescriptions, progress notes and reports.
- **Screen Refresh Settings:**
    - **Scheduling-** This field determines how often the Scheduling screen will automatically refresh.
    - **Office/Patient Locator-** This field determines how often the Patient Locator screen in the Office area will automatically refresh.
    - **Messages-** This field determines how often the Messages screen will automatically refresh.

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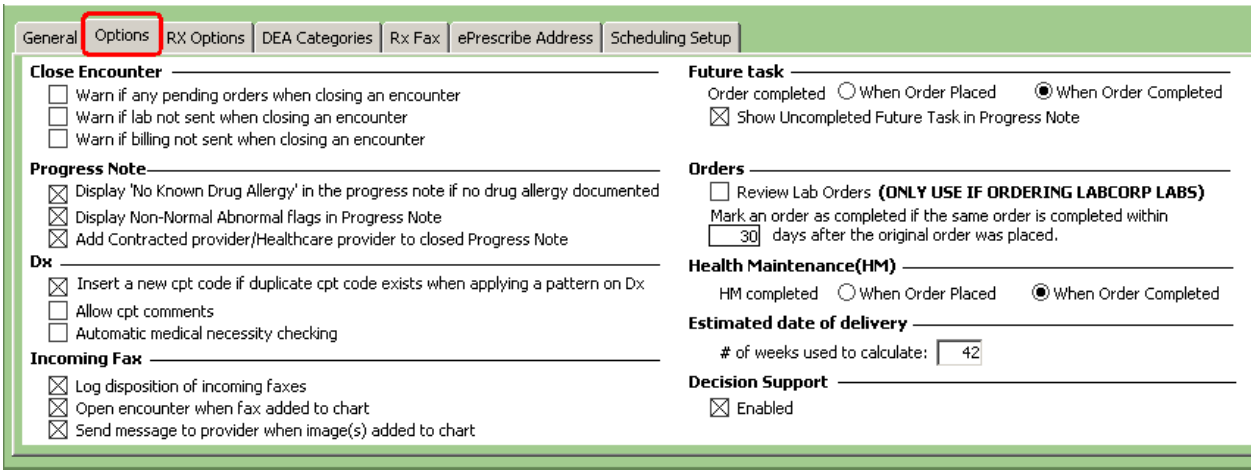
B. Options:


General
Options
RX Options
DEA Categories
Rx Fax
ePrescribe Address
Scheduling Setup
Close Encounter
Warn if any pending orders when closing an encounter
Warn if lab not sent when closing an encounter
Warn if billing not sent when closing an encounter
Progress Note
Display 'No Known Drug Allergy' in the progress note if no drug allergy documented
Display Non-Normal Abnormal flags in Progress Note
Add Contracted provider/Healthcare provider to closed Progress Note
Dx
Insert a new cpt code if duplicate cpt code exists when applying a pattern on Dx
Allow cpt comments
Automatic medical necessity checking
Incoming Fax
Log disposition of incoming faxes
Open encounter when fax added to chart
Send message to provider when image(s) added to chart
Future task
Order completed
When Order Placed
When Order Completed
Show Uncompleted Future Task in Progress Note
Orders
Review Lab Orders (ONLY USE IF ORDERING LABCORP LABS)
Mark an order as completed if the same order is completed within
30
days after the original order was placed.
Health Maintenance(HM)
HM completed
When Order Placed
When Order Completed
Estimated date of delivery
# of weeks used to calculate:
42
Decision Support
Enabled

- **Close Encounter –** Checking these boxes will: warn if Labs, Pending Orders or Billing has not been sent.

- **Progress Note** – Checking these boxes will: display "No Known Drug Allergy" in the progress note if no drug allergy documented; display non-normal "Abnormal Flags" (in lab results) in the progress note; add the contracted/healthcare provider to the closed progress note.

- **Diagnosis (Dx) –** Checking these boxes will: allow for inserting a CPT if duplicate exists in pattern or procedure, allows CPT comments and automatic medical necessity checking.

- **Incoming Fax –** Checking these boxes will: Log disposition of incoming faxes (this is for the Fax Audit Log); automatically open an encounter when adding fax to chart; send message to provider (the contracted provider listed in the encounter) when image(s) are added to chart.

- **Future Task** - Will complete a future task either:" When Order Placed" or "When Order Completed." Mark the "Show Uncompleted Future Task(s) in Progress Note" check-box, if needed.

- **Orders** – Check box to Review Lab Orders (ONLY USE IF ORDERING LABCORP LABS). Set the threshold by number of days to mark an order as completed if the same order is completed within (# of days) after the original order was placed.

- **Health Maintenance** – Will mark a health maintenance item as complete either: "When Order Placed" or "When Order Completed."

- **Estimated Date of Delivery** – Number of weeks to calculate delivery date.

- **Decision Support -** Turns on the Clinical Decision Support tool for the location (Clinical Decision Support rules are established in Clinic Setup).

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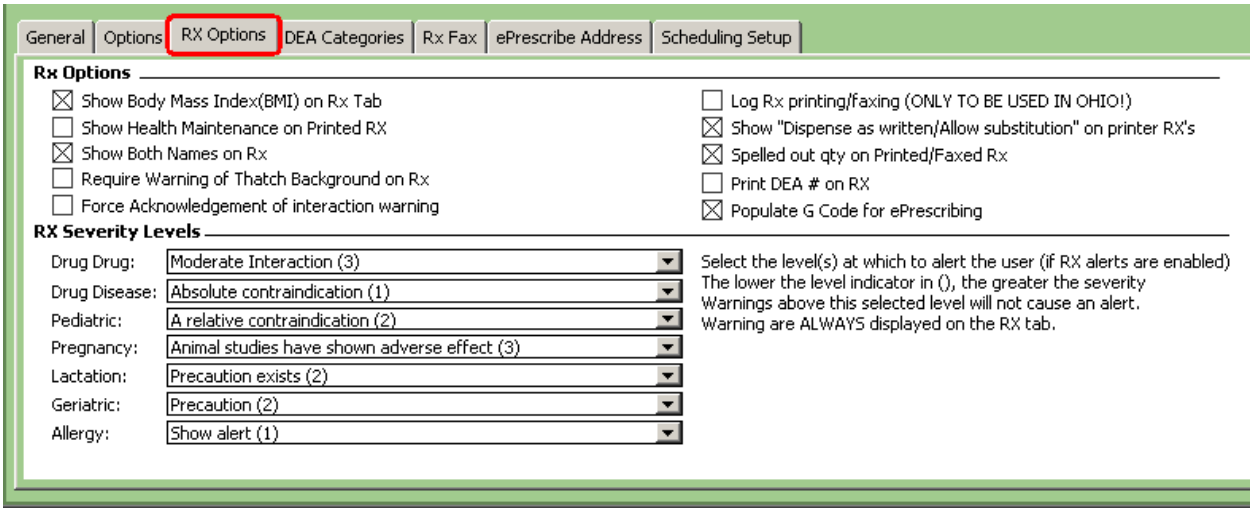
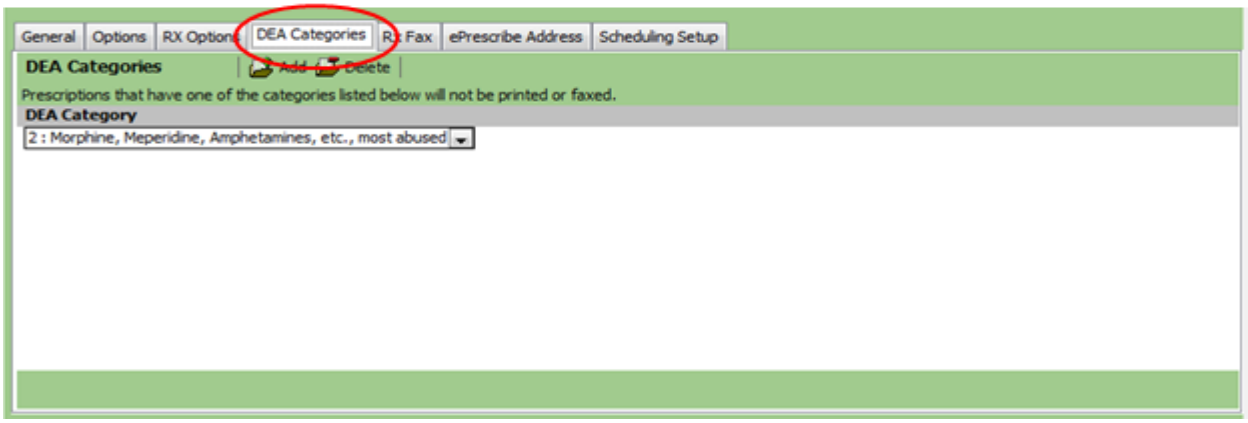
C. RX Options


General
Options
RX Options
DEA Categories
Rx Fax
ePrescribe Address
Scheduling Setup
Rx Options
Show Body Mass Index(BMI) on Rx Tab
Show Health Maintenance on Printed RX
Show Both Names on Rx
Require Warning of Thatch Background on Rx
Force Acknowledgement of interaction warning
Log Rx printing/faxing (ONLY TO BE USED IN OHIO!)
Show "Dispense as written/Allow substitution" on printer RX's
Spelled out qty on Printed/Faxed Rx
Print DEA # on RX
Populate G Code for ePrescribing
RX Severity Levels
Drug Drug: Moderate Interaction (3)
Drug Disease: Absolute contraindication (1)
Pediatric: A relative contraindication (2)
Pregnancy: Animal studies have shown adverse effect (3)
Lactation: Precaution exists (2)
Geriatric: Precaution (2)
Allergy: Show alert (1)
Select the level(s) at which to alert the user (if RX alerts are enabled)
The lower the level indicator in (), the greater the severity
Warnings above this selected level will not cause an alert.
Warning are ALWAYS displayed on the RX tab.

- **RX Options –**
  - Checking boxes will Show Body Mass Index (BMI) on RX tab (needed for auto-calculation of BMI in Vitals)
  - Show Health Maintenance on Printed RX
  - Show Both Names on RX
  - Require Warning of Thatch Background on RX
  - Log RX printing/faxing (ONLY TO BE USED IN OHIO ONLY)
  - Show “Dispense as written/Allow substitution” on printer RX’s
  - Spelled out quantity on Printed/Faxed RX
  - Print DEA # on RX
  - The “Populate “G” code for ePrescribing” box (for Medicare ePrescribe incentive tracking: must be marked to automatically add this code to the ‘Diagnosis’ tab of an encounter if utilizing ePrescribe for patients with Medicare as their primary insurance).

- **RX Severity Levels** – Select severity interaction level for the Drug, Disease, Pediatric, Pregnancy, Lactation and Geriatric pop-up warnings (this is turned on at the user level). Can select to turn Allergy pop-up warnings on or off.

D. DEA Categories



- **DEA Categories -** Prescriptions that have one of the categories listed will not be printed or faxed.

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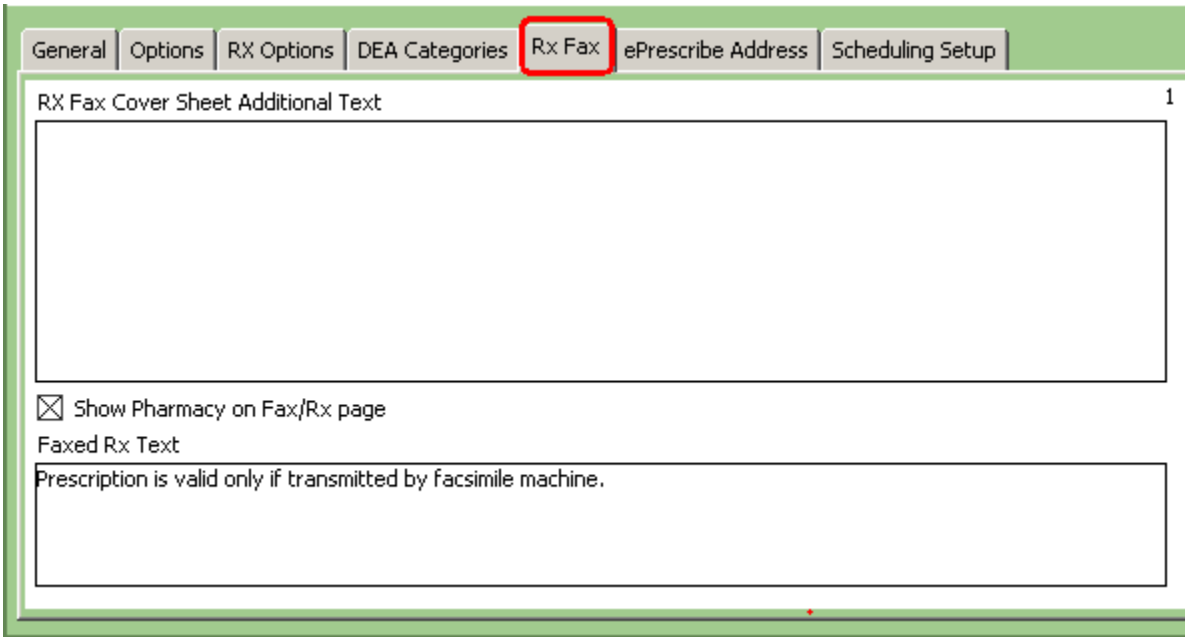
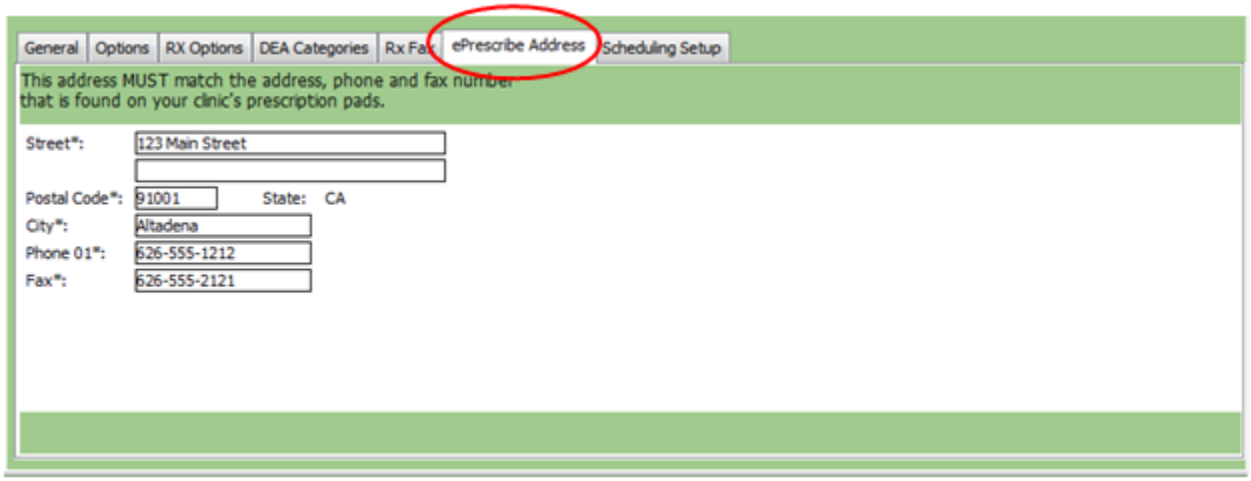
E. RX Fax



- **RX Fax Coversheet -** This area allows free text entry that will display on an RX fax header.
- **Show Pharmacy on Fax/RX Page** – Marking this check-box will add the pharmacy information onto the face of the faxed prescription.
- **Faxed RX Text**- This area allows free text entry that will display on the face of the faxed prescription.

F. ePrescribe Address



- **This address MUST match the address, phone and fax number that is found on your clinic's prescription pads.**

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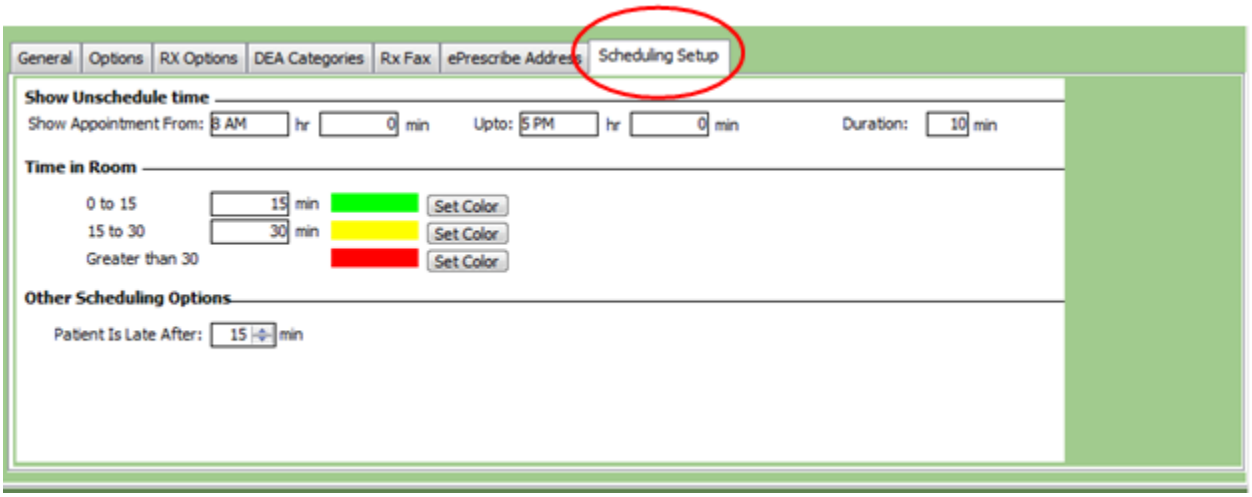
G. Scheduling Setup



- **Show Unscheduled time** - Default clinic appointment availability time and duration of appointments.
- **Time in Room** – Default increment times and set color (this is displayed in the Patient Locator).
- **Other Scheduling Options –** Set the default “Late” time period

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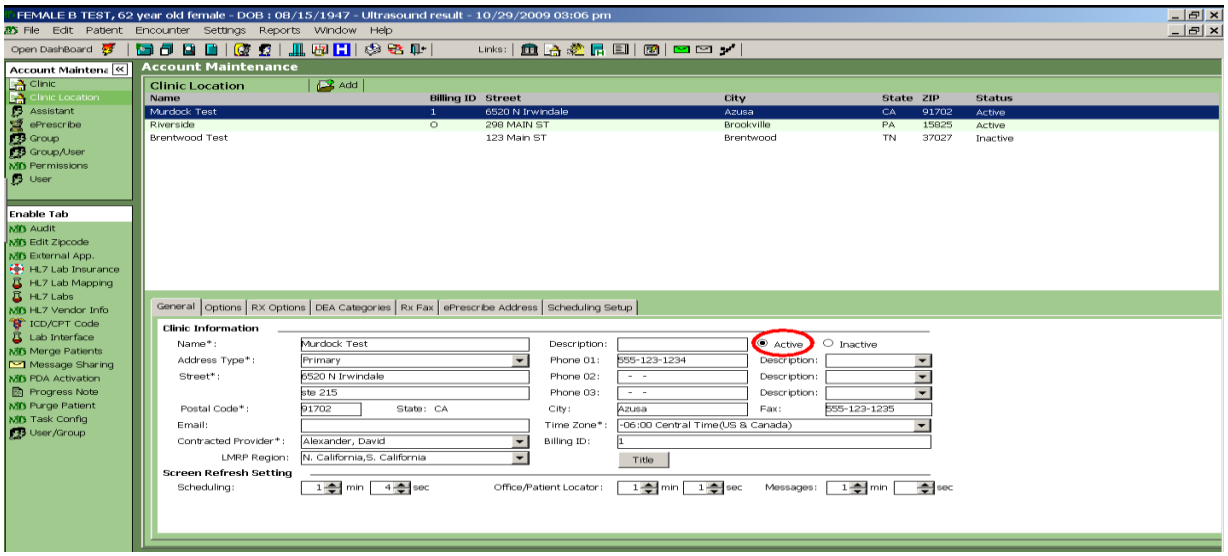
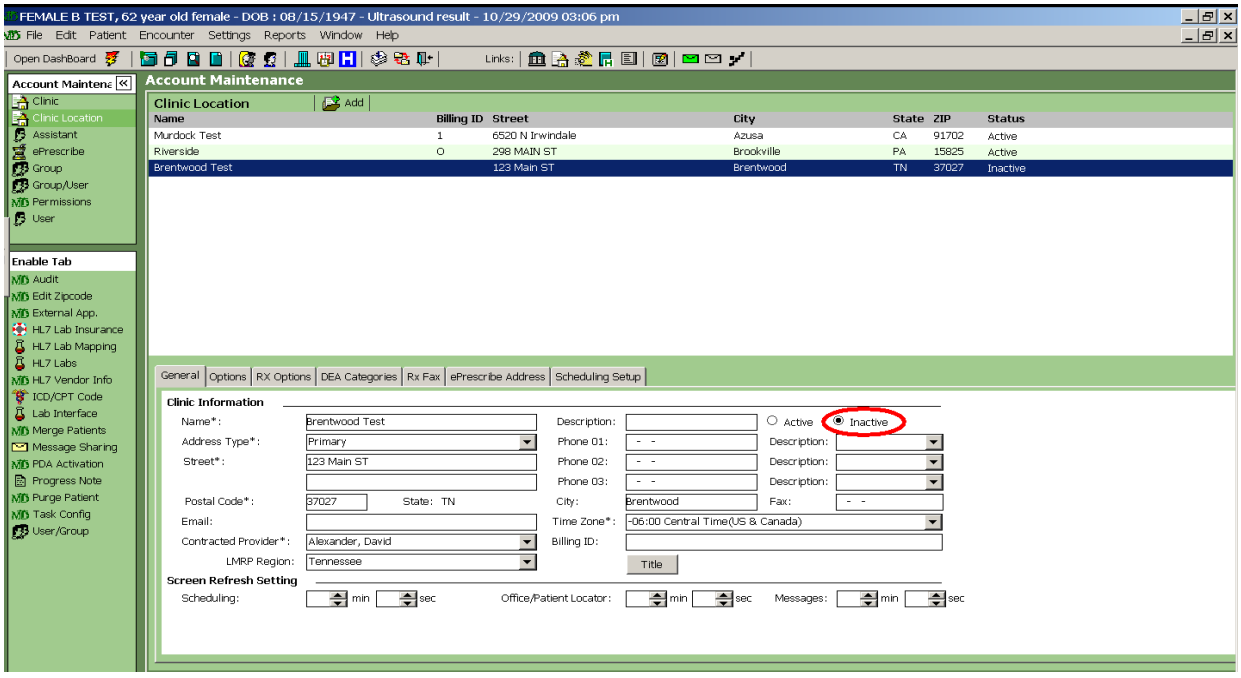
3. ADDING A CLINIC LOCATION

To add a location, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Clinic Location*.
b. Place your cursor in the Detail pane, located on the bottom of the Clinic Location tab, by clicking anywhere in that section.
c. Click the **Add** button located to the right of **Clinic Location.**
d. Fill in the appropriate information for the location (all fields marked with an asterisk (*) are required). The “Active” radio button is selected by default.
e. Repeat steps a-d as needed to list all locations associated with a clinic.


FEMALE B TEST, 62 year old female - DOB : 08/15/1947 - Ultrasound result - 10/29/2009 03:06 pm
File Edit Patient Encounter Settings Reports Window Help
Account Maintenance
Clinic Location
Add
Name Billing ID Street City State ZIP Status
Murdock Test 1 6520 N Irwindale Azusa CA 91702 Active
Riverside O 298 MAIN ST Brookville PA 15825 Active
Brentwood Test 123 Main ST Brentwood TN 37027 Inactive
General Options RX Options DEA Categories Rx Fax ePrescribe Address Scheduling Setup
Clinic Information
Name*: Murdock Test
Address Type*: Primary
Street*: 6520 N Irwindale
ste 215
Postal Code*: 91702 State: CA
Email:
Contracted Provider*: Alexander, David
LMRP Region: N. California,S. California
Description:
Phone 01: 555-123-1234
Phone 02:
Phone 03:
City: Azusa
Time Zone*: -06:00 Central Time(US & Canada)
Billing ID: 1
Title
Active
Inactive
Fax: 555-123-1235
Screen Refresh Setting
Scheduling:
Office/Patient Locator:
Messages:

Note: Clinic locations cannot be deleted. They can be deactivated by selecting the “Inactive” radio button. Once a location has been rendered inactive, users will no longer be able to select it.


FEMALE B TEST, 62 year old female - DOB : 08/15/1947 - Ultrasound result - 10/29/2009 03:06 pm
File Edit Patient Encounter Settings Reports Window Help
Account Maintenance
Clinic Location
Add
Name Billing ID Street City State ZIP Status
Murdock Test 1 6520 N Irwindale Azusa CA 91702 Active
Riverside O 298 MAIN ST Brookville PA 15825 Active
Brentwood Test 123 Main ST Brentwood TN 37027 Inactive
General Options RX Options DEA Categories Rx Fax ePrescribe Address Scheduling Setup
Clinic Information
Name*: Brentwood Test
Address Type*: Primary
Street*: 123 Main ST
Postal Code*: 37027 State: TN
Email:
Contracted Provider*: Alexander, David
LMRP Region: Tennessee
Description:
Phone 01:
Phone 02:
Phone 03:
City: Brentwood
Time Zone*: -06:00 Central Time(US & Canada)
Billing ID:
Title
Active
Inactive
Fax:
Screen Refresh Setting
Scheduling:
Office/Patient Locator:
Messages:

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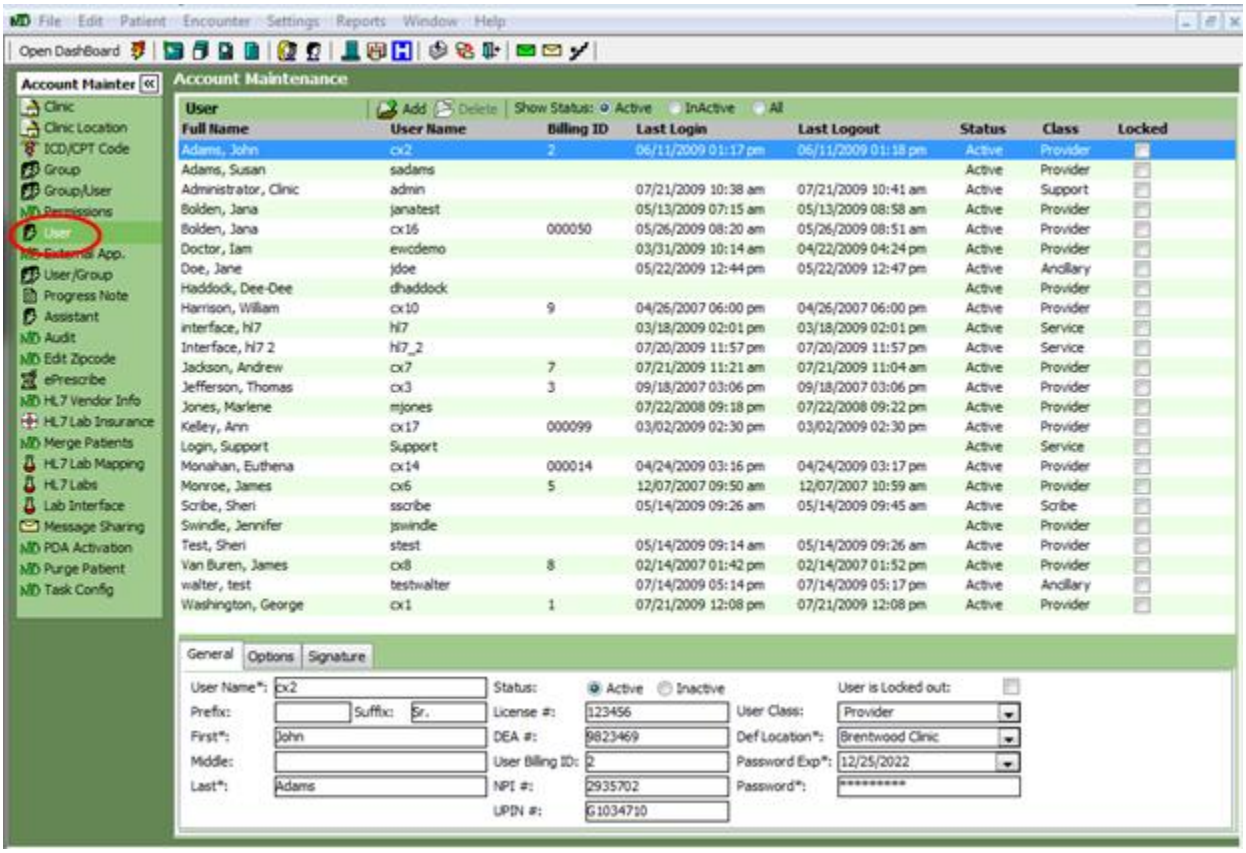
4. USER

The ‘User’ tab contains information on all ClinixMD users. The ‘User’ tab is divided into two panes. The top User List pane displays limited user information on a single line. The data is organized using the following headings:

- **Full Name**
- **User Name**
- **Last Login**
- **Last Logout**
- **Status (Active or Inactive)**
- **Class**
- **Locked status (if user is locked out, a check mark will be in this box.)**


File Edit Patient Encounter Settings Reports Window Help
Open DashBoard
Account Mainter
Account Maintenance
Clinic
Clinic Location
ICD/CPT Code
Group
Group/User
Permissions
User
External App.
User/Group
Progress Note
Assistant
Audit
Edit Zipcode
ePrescribe
HL7 Vendor Info
HL7 Lab Insurance
Merge Patients
HL7 Lab Mapping
HL7 Labs
Lab Interface
Message Sharing
PDA Activation
Purge Patient
Task Config
User
Add
Delete
Show Status: Active InActive All
Full Name | User Name | Billing ID | Last Login | Last Logout | Status | Class | Locked
Adams, John | cx2 | 2 | 06/11/2009 01:17 pm | 06/11/2009 01:18 pm | Active | Provider
Adams, Susan | sadams | | | | Active | Provider
Administrator, Clinic | admin | | 07/21/2009 10:38 am | 07/21/2009 10:41 am | Active | Support
Bolden, Jana | janatest | | 05/13/2009 07:15 am | 05/13/2009 08:58 am | Active | Provider
Bolden, Jana | cx16 | 000050 | 05/26/2009 08:20 am | 05/26/2009 08:51 am | Active | Provider
Doctor, Iam | ewcdemo | | 03/31/2009 10:14 am | 04/22/2009 04:24 pm | Active | Provider
Doe, Jane | jdoe | | 05/22/2009 12:44 pm | 05/22/2009 12:47 pm | Active | Ancillary
Haddock, Dee-Dee | dhaddock | | | | Active | Provider
Harrison, William | cx10 | 9 | 04/26/2007 06:00 pm | 04/26/2007 06:00 pm | Active | Provider
interface, hl7 | hl7 | | 03/18/2009 02:01 pm | 03/18/2009 02:01 pm | Active | Service
Interface, hl7 2 | hl7_2 | | 07/20/2009 11:57 pm | 07/20/2009 11:57 pm | Active | Service
Jackson, Andrew | cx7 | 7 | 07/21/2009 11:21 am | 07/21/2009 11:04 am | Active | Provider
Jefferson, Thomas | cx3 | 3 | 09/18/2007 03:06 pm | 09/18/2007 03:06 pm | Active | Provider
Jones, Marlene | mjones | | 07/22/2008 09:18 pm | 07/22/2008 09:22 pm | Active | Provider
Kelley, Ann | cx17 | 000099 | 03/02/2009 02:30 pm | 03/02/2009 02:30 pm | Active | Provider
Login, Support | Support | | | | Active | Service
Monahan, Euthena | cx14 | 000014 | 04/24/2009 03:16 pm | 04/24/2009 03:17 pm | Active | Provider
Monroe, James | cx6 | 5 | 12/07/2007 09:50 am | 12/07/2007 10:59 am | Active | Provider
Scribe, Sheri | sscribe | | 05/14/2009 09:26 am | 05/14/2009 09:45 am | Active | Scribe
Swindle, Jennifer | jswindle | | | | Active | Provider
Test, Sheri | stest | | 05/14/2009 09:14 am | 05/14/2009 09:26 am | Active | Provider
Van Buren, James | cx8 | 8 | 02/14/2007 01:42 pm | 02/14/2007 01:52 pm | Active | Provider
walter, test | testwalter | | 07/14/2009 05:14 pm | 07/14/2009 05:17 pm | Active | Ancillary
Washington, George | cx1 | 1 | 07/21/2009 12:08 pm | 07/21/2009 12:08 pm | Active | Provider
General
Options
Signature
User Name*: cx2
Prefix:
Suffix: Sr.
First*: John
Middle:
Last*: Adams
Status: Active Inactive
License #: 123456
DEA #: 9823469
User Billing ID: 2
NPI #: 2935702
UPIN #: G1034710
User is Locked out:
User Class: Provider
Def Location*: Brentwood Clinic
Password Exp*: 12/25/2022
Password*: *********

The lower pane contains information that is more detailed and is organized with the following:

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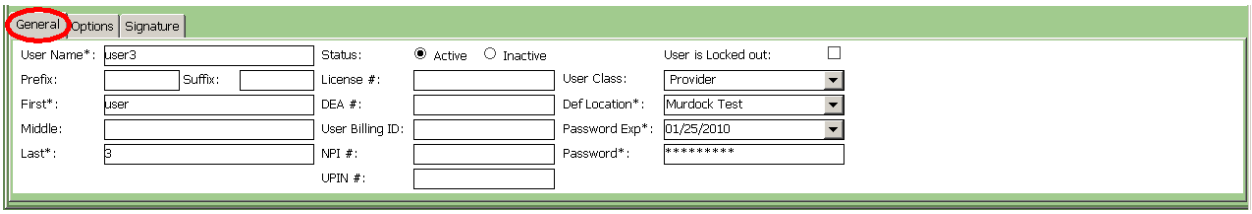
A. General



- **User Name** (required) – This field is available for creating a User Name. A User Name can be up to 20 characters in length. This name can consists of numbers, letters or a combination of both.
- **Prefix** – This field is used to enter a prefix for the user such as Mr., Mrs. Dr. etc.
- **Suffix** – User's suffix such as MD, PhD, RN etc.
- **First** (required) - User's first name.
- **Middle** – User's middle name.
- **Last** (required) - User's last name.
- **Status –** The status radio buttons allow you to identify a user's status with regards to the CLINIXMD application. An active user is one who currently has access to the CLINIXMD application. Marking a user Inactive removes access to the application but still keeps a record of the user in the database.
- **License** – Medical License numbers.
- **DEA# -** Drug Enforcement Agency number assigned to physicians.
- **User Billing ID**: This ID is used in connection with a billing system. This number should match the billing ID given to a user who handles patient billing.
- **NPI #**
- **UPIN #**
- **User is Locked Out –** Check if the user is no longer authorized to access CLINIXMD. Additionally, if a user attempts to login three times (in one minute) with incorrect information, the system will automatically lock them out. To unlock user, click the box to remove check.
- **User Class**- This drop-down Selection allows you to choose which license type will be set as the default for the user.
- **Def Location** – This drop-down Selection allows you to choose which location will be set as the default for a user. This setting helps maintain security for multiple locations.
- **Password Exp** (required) - This field is used to enter an expiration date for the user. Once the date is set, a user must change the password to maintain security.
- **Password** (required) – This field is a 16-character field that uses one-way encryption to secure the password. The password can be alpha or numeric and displays as a series of asterisks (*******). **Note:** Due to the encryption attached to passwords, it is not possible to retrieve this information. If a user forgets the password, the administrator must create a new password. The encryption for passwords also applies to online users and protects against security breaches that can occur with the transmission of information over the Internet.

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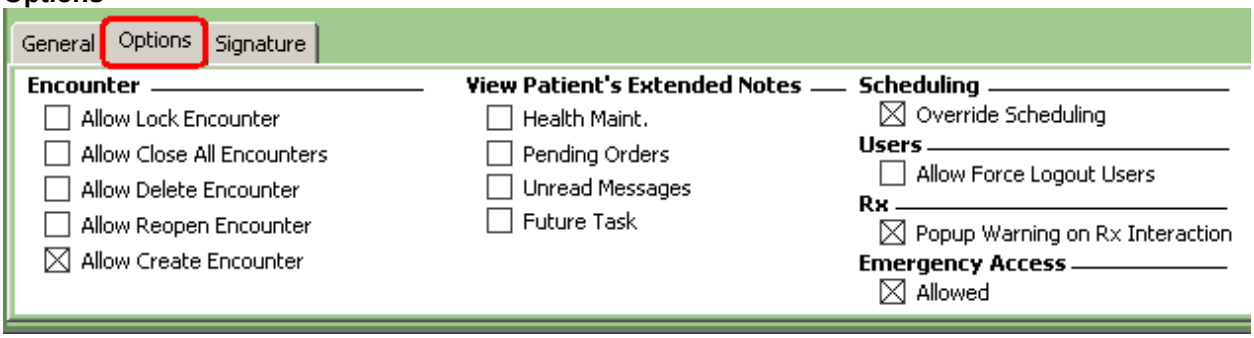
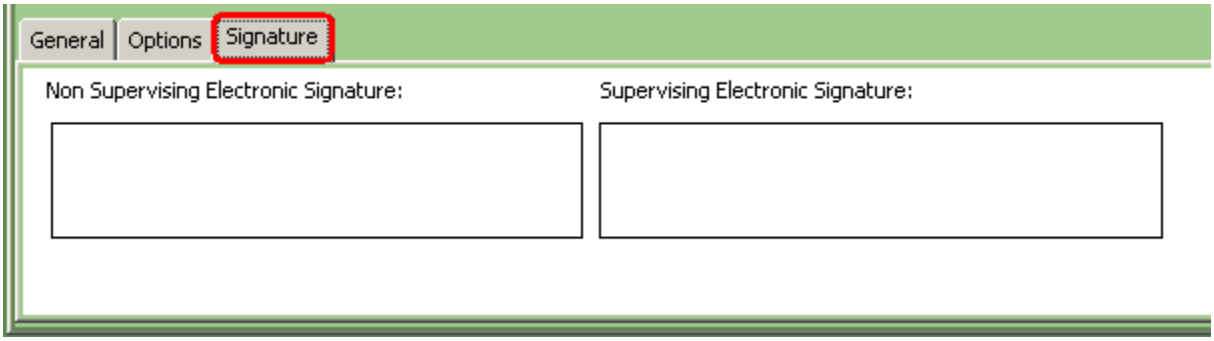
B.
Options



- **Encounter –** Allows the user to: Lock, Close All, Delete, Reopen and Create encounters
- **View Patient's Extended Notes**- View Health Maintenance, Pending Orders, Unread Messages and Future Tasks
- **Scheduling**- Selecting this check-box will allow the user to Override Scheduling
- **Users –** Selecting this check-box box allows the user to Force Logout Users in the "Active Users" tab in the Office area.
- **RX** - Selecting this check-box turns on the RX Interaction pop-up warnings
- **Emergency Access-** Selecting this check-box allows the user to access the Emergency Access feature

C. Signature



- **Non Supervising Signature-** add the verbiage "Assisted By:_____"
- **Supervising Signature-** add the electronic signature (i.e. "This has been electronically signed by:_____. Password Protected.")
- **Import Signature**- This is needed for printed and faxed prescriptions. To add a signature, select the *Import Signature* button and either scan the signature directly in or import the signature from a bitmap (.bmp) file. Note: The size of the signature cannot exceed 2.5"W X 0.5" H.

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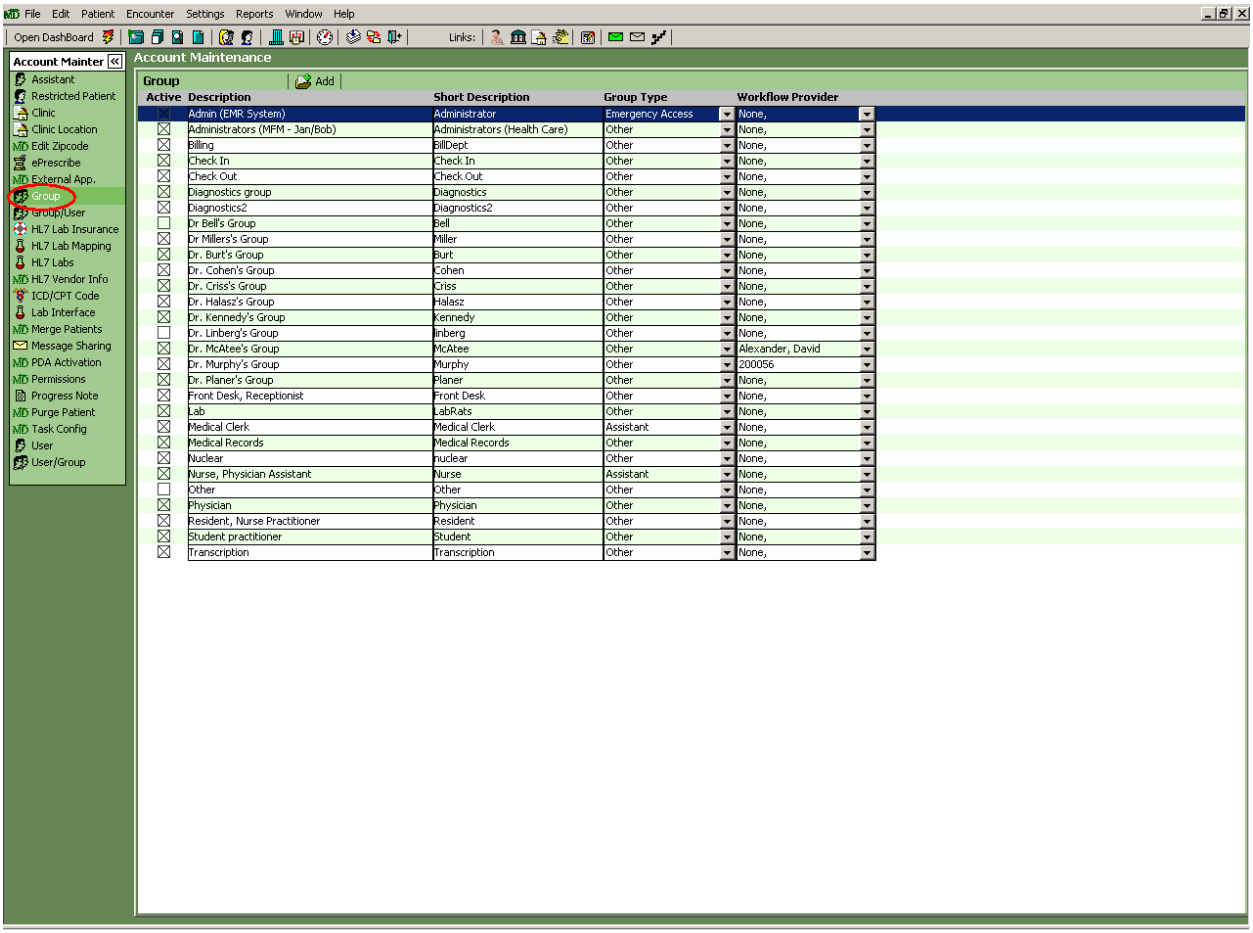
5. GROUP

The 'Group' tab is used to maintain the User Groups for your facility. User Groups help you organize the staff based on job functionality. The creation of User Groups plays a major role in establishing permissions, maintaining security and establishing emergency access to authorized users. Once User Groups are created, permissions can be granted according to job duties/responsibilities and users can be placed in the appropriate group(s).



The tab consists of the following:

- **"Active" designation**
- **Description**
- **Short Description**
- **Group Type**
- **Workflow Provider**

The Groups created in this tab will affect the selections made in the User/Group and Group/User tabs.

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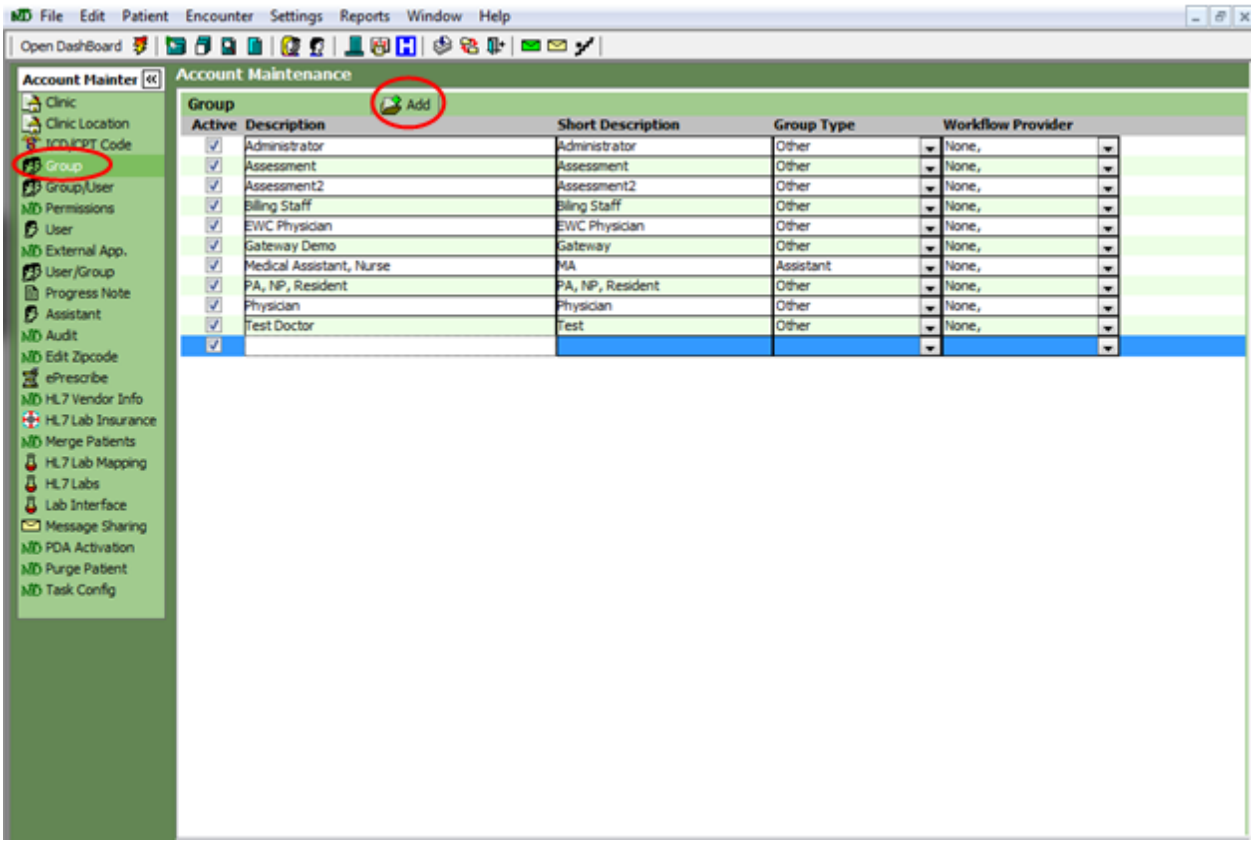
6. ADDING A GROUP

Note: Groups cannot be deleted; they can only be deactivated by removing the check-mark in the “Active” field. Once they are rendered inactive, they will no longer be a choice in the associated window drop-downs and will appear as a series of numbers if there are users assigned to the now inactive group. Additionally, this is where you specify which group will be given “Emergency Access” privileges (typically, this will be assigned to the Administrator group).

**Emergency Access is to be used to grant users access to information they would typically not have access to in the event of an urgent situation. Once the user enters the system in emergency access mode, they will have rights to view tabs they are currently authorized to view as well as those assigned to the “Emergency Access” group. This can be accessed in the “Patient” drop-down menu in the ClinixMD Menubar.



To add a Group, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Group*
b. Click the “**Add”** button located to the right of **Group**. A new row appears in the Group tab.
c. Select the *Active* box to ensure that the Group created will be active.
d. Fill in the Description for the Group and enter a Short Description for the Group.
e. Select “Other” in **Group Type** if this group will have normal privileges; select “Emergency Access” if you wish this to be the emergency access group. If the Group will be assigned to a specific provider (rarely used) for workflow tasks, select which provider the Group will be assigned to; otherwise, select “None.”

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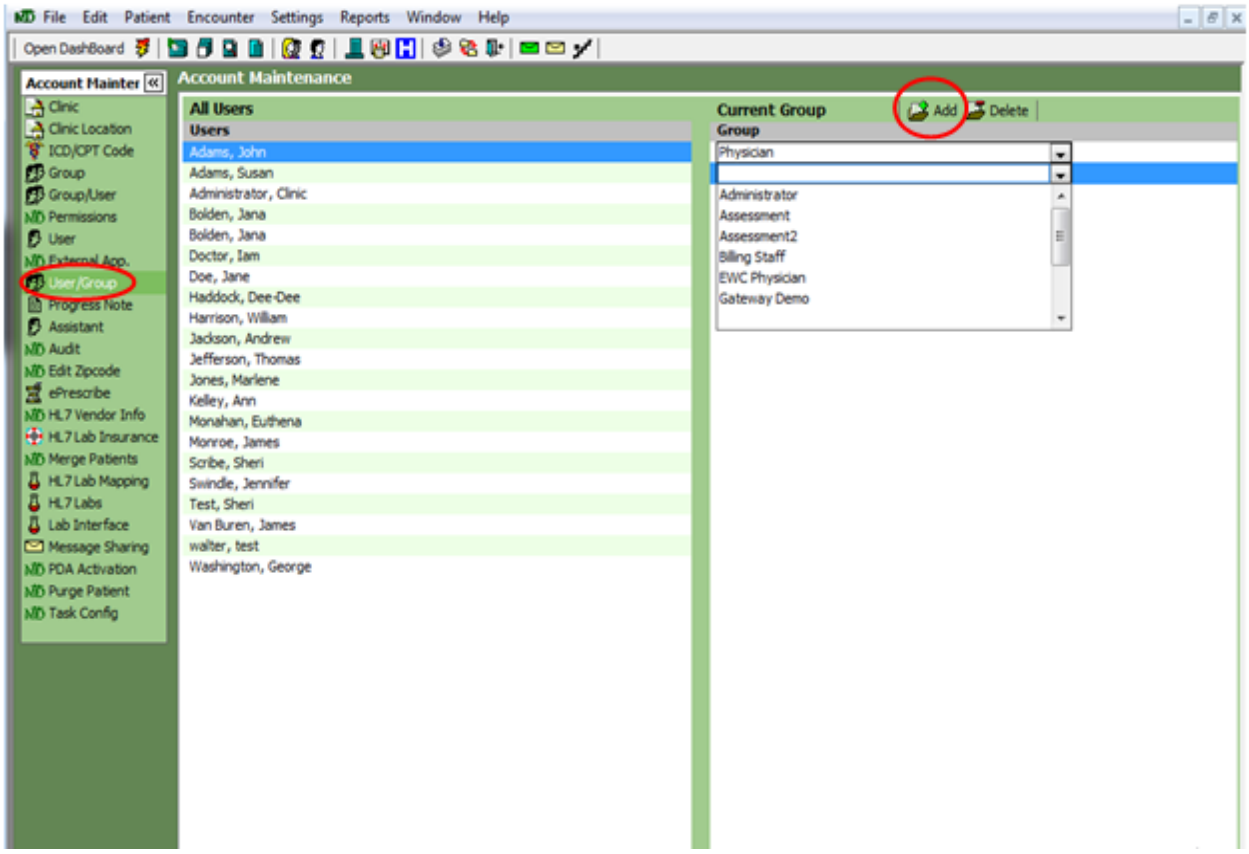
7. USER/GROUP

The 'User/Group' tab is used to assign users to specific groups. This tab is divided into two panes. The first pane labeled All Users and contains a list of the users for the clinic. The second pane, Current Group, shows the users assigned to the particular Group.



To assign a User to a Group, follow the steps outlined below:

a. Select *Settings->Account Maintenance->User/Group*.
b. Highlight the User you want to assign a Group to from the list provided in the All Users pane.
c. Click on the *Current Group* pane to activate this area.
d. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A drop-down list box displays.
e. Select the appropriate *Group* from the drop-down list
f. Repeat steps c – e to add more groups to a specific user.

To delete a User from a Group, follow the steps outlined below:

a. Select *Settings->Account Maintenance->User/Group.*
b. Highlight the User you wish to work with from the All Users pane.
c. Highlight the *Group* you want to delete from the Current Group pane.
d. Click the **Delete** icon from the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
e. Confirm your deletion by clicking *OK*.

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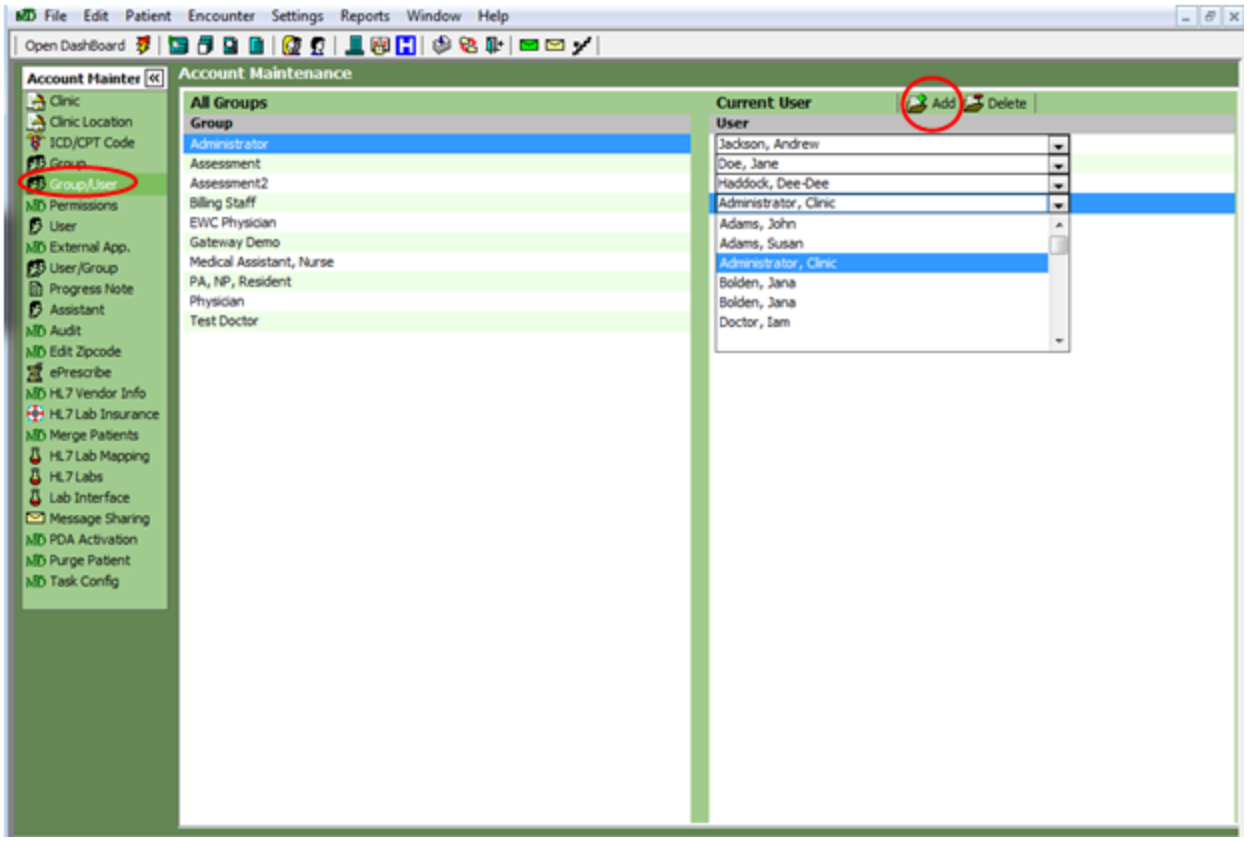
8. GROUP/USER

The 'Group/User' tab displays a complete list of users and allows the administrator to assign a group to a specific user. This tab is divided into two panes: the **All Groups** pane displays a list of the ClinixMD groups and the **Current User** pane displays the users assigned to the group. Users can be matched up with groups so that security can be maintained for different personnel; a user can be a member of multiple Groups, if needed.



To assign a Group to a User, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Group/User.*
b. Highlight the *Group* you want to assign a user to from the list provided in the All Groups pane.
c. Click on the *Current User* pane to activate this area.
d. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A drop-down list box displays.
e. Select the appropriate user from the drop-down list
f. Repeat steps c – e to add more users to a specific user.

To delete a Group from a User, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Group/User.*
b. Highlight the *Group* you wish to work with from the All Groups pane.
c. Highlight the *User* you want to delete from the Current User pane.
d. Click the **Delete** icon from the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
e. Confirm your deletion by clicking *OK*.

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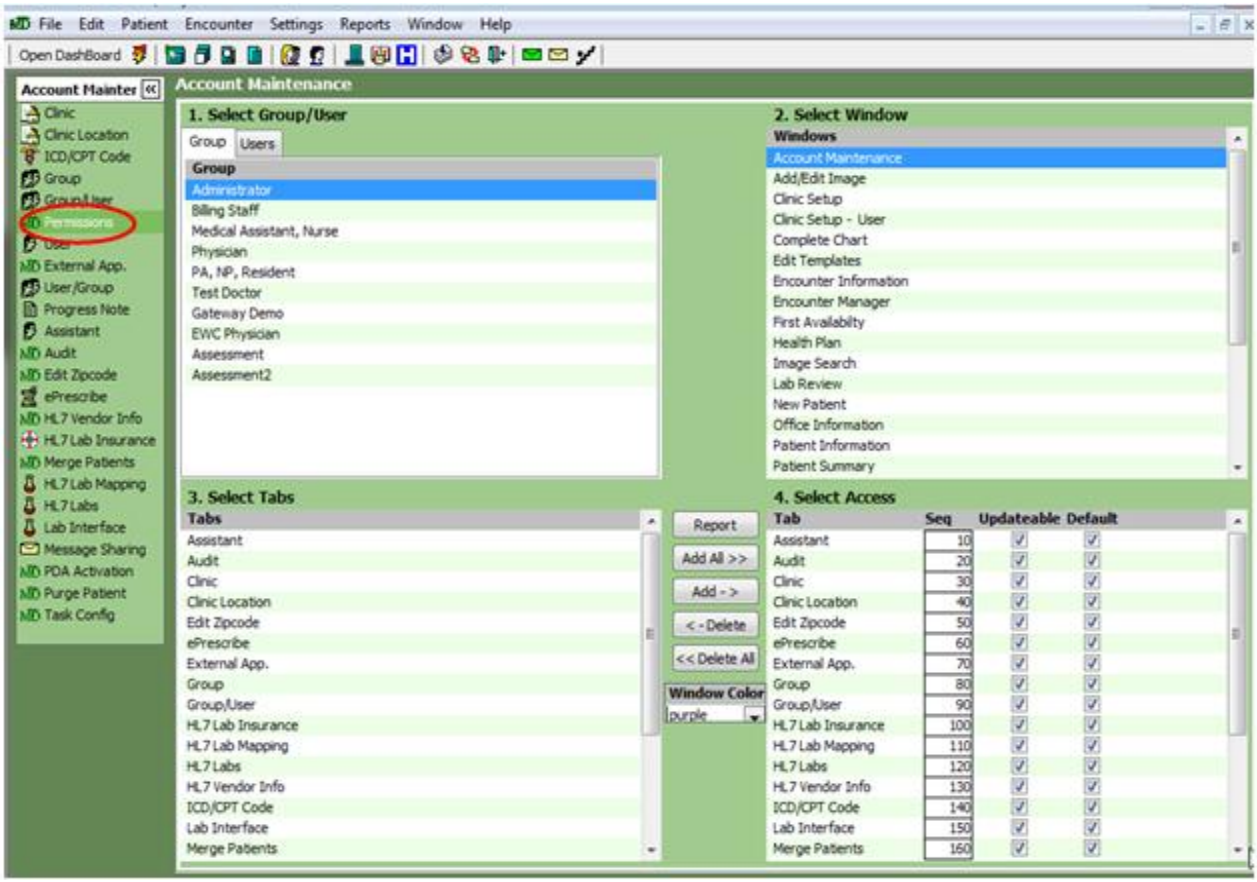
9. PERMISSIONS

The 'Permissions' tab is used to establish system access for the various groups; additional permissions (outside of the normal permissions for the group) can be assigned to a user, if needed.



This tab also allows for the customization of tabs within a window. Tabs can be sequenced to best reflect workflow. This window is comprised of the following panes:

- Select **Group/User** – **User/Group** - This pane shows a list of users and is available for granting or removing access rights to certain areas in the application. This is the first selection in granting permissions.
- Select **Window**- This pane shows a list of windows available to the User. This is the second step in assigning permissions.
- Select **Tabs** – This pane lists the tabs found in a particular window. Access rights are handled at this level. Users can have access to a selected amount of tabs or all tabs depending on the role of the user in clinic and the security structure created by the administrator. This is the third step in granting permissions.
- Select **Access** – The User Access pane lists the tabs that a particular user can access. The administrator can limit the access by removing the check in the Updateable checkbox. This would allow a User to see the information in a tab without having the ability to change the information. Another option available to the user is the sequencing of tabs. Tabs can be rearranged to suit a User's preference. Changing the numeric values in this sequence field changes the order in which the tabs are displayed. Sequenced numbers are listed in increments of 10.

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Granting Permissions

To grant permissions to a Group or User, follow the steps outlined below:

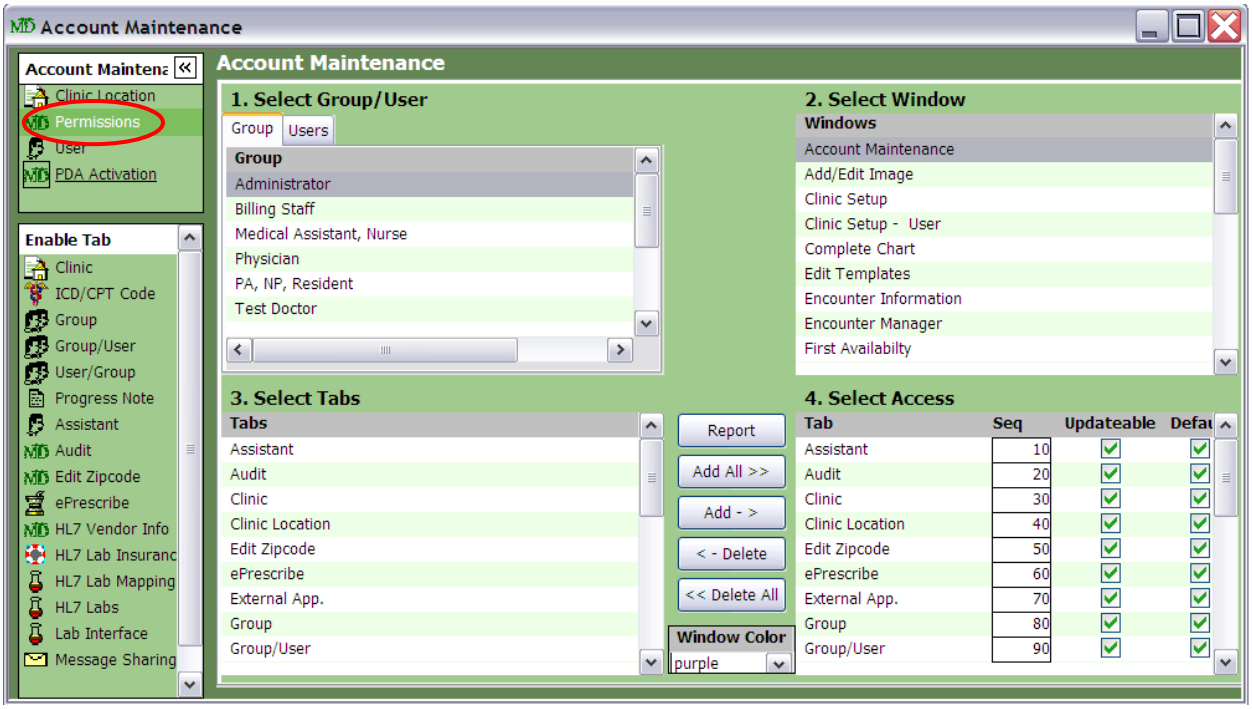
a. Select *Settings->Account Maintenance->Permissions*
b. Highlight the *Group* or *User* from the list in the Group User/User Group pane.
c. Select the *Window* you wish to use in granting permissions from the list in the window pane.
d. From the Tabs pane, use the list to select the Tabs you want the selected user or group to access. You can make several selections at once by simply clicking on the *Tab* from the list. Once all the selections are made click the **Add** button to move your selections from the Tabs pane to the Access pane. Also available is the ability to **Add All** tabs by selecting the **Add All** button.

Removing Permissions

To remove permissions from a Group or User, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Permissions*
b. Highlight the *Group* or *User* from the list in the Group/Users/User Group pane.
c. Select the *Window* you wish to use in removing permissions from the list in the window pane.
d. From the Access pane, select one or several Tabs you want to remove from the User. Multiple Selections can be made from the Access pane by clicking on the *Tabs*. Once all the choices are made, click the **Delete** button to remove your selections from the Access pane back to the Tabs pane. Also available is the ability to delete all tabs by clicking the **Delete All** button.

The default color for the window is also set from Permissions. After completing the steps above, choose the color choice by clicking the drop-down as seen in the screen below:



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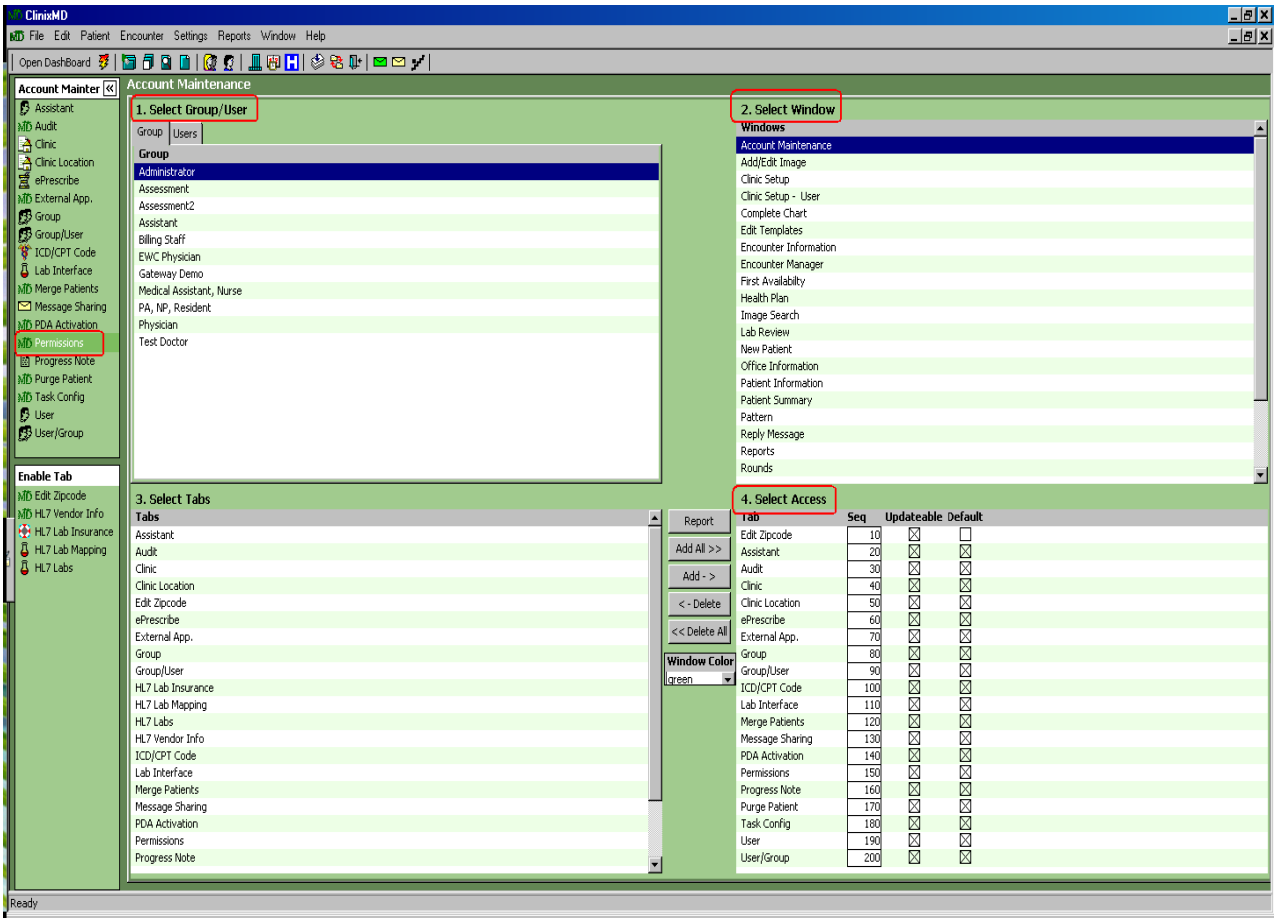
10. TAB SEQUENCING

The order in which tabs appear in each window can be modified in the 'Permissions' tab. It can also be set at the user level either by selecting the "User Preference" icon from the ClinixMD desktop or the administrator can modify the sequence for a user from the User Set-Up menu.



To sequence tabs in the ClinixMD windows, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Permissions*
b. Select the applicable group/user from the **Select Group/User** pane.
c. Select the desired window (i.e. Account Maintenance, Encounter Information, etc.) from the **Select Window** pane.
d. In the **Select Access** pane, enter a number less than 10 to place the tab you select in first position; enter a number between 10 and 20 in the tab that you want to appear in the second position.
e. Follow the same logic to arrange the remaining tabs in the order desired.

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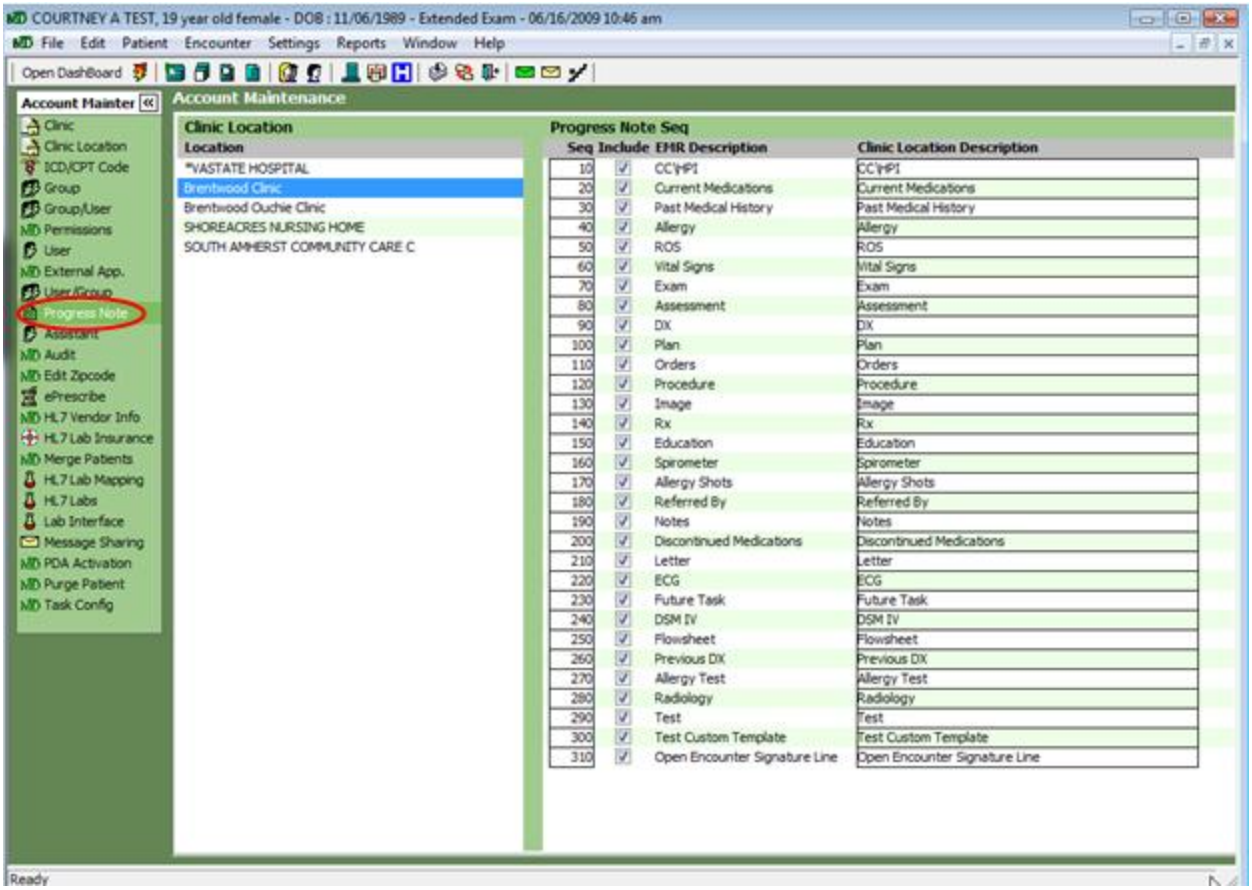
11. PROGRESS NOTE: SEQUENCE AND DESCRIPTION

The Edit 'Progress Note' Sequence tab is used to sort the Progress Note tabs. Additionally, the description of the sections included in the Progress Note can be modified in this tab.



To sequence a Progress Note, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Progress Note Seq.*
b. Select the *Clinic Location*.
c. Place the Progress Note tabs in order by sequencing the tabs as needed. Tab sequencing is done in multiples of 10.
d. Enter a number less than 10 to place the tab you select in first position.
e. Enter a number between 10 and 20 in the tab that you want to appear in the second position.
f. Follow the same logic to arrange the remaining tabs in the order desired.
g. By selecting the "*Include"* checkbox, the tab will display in the Progress Note.

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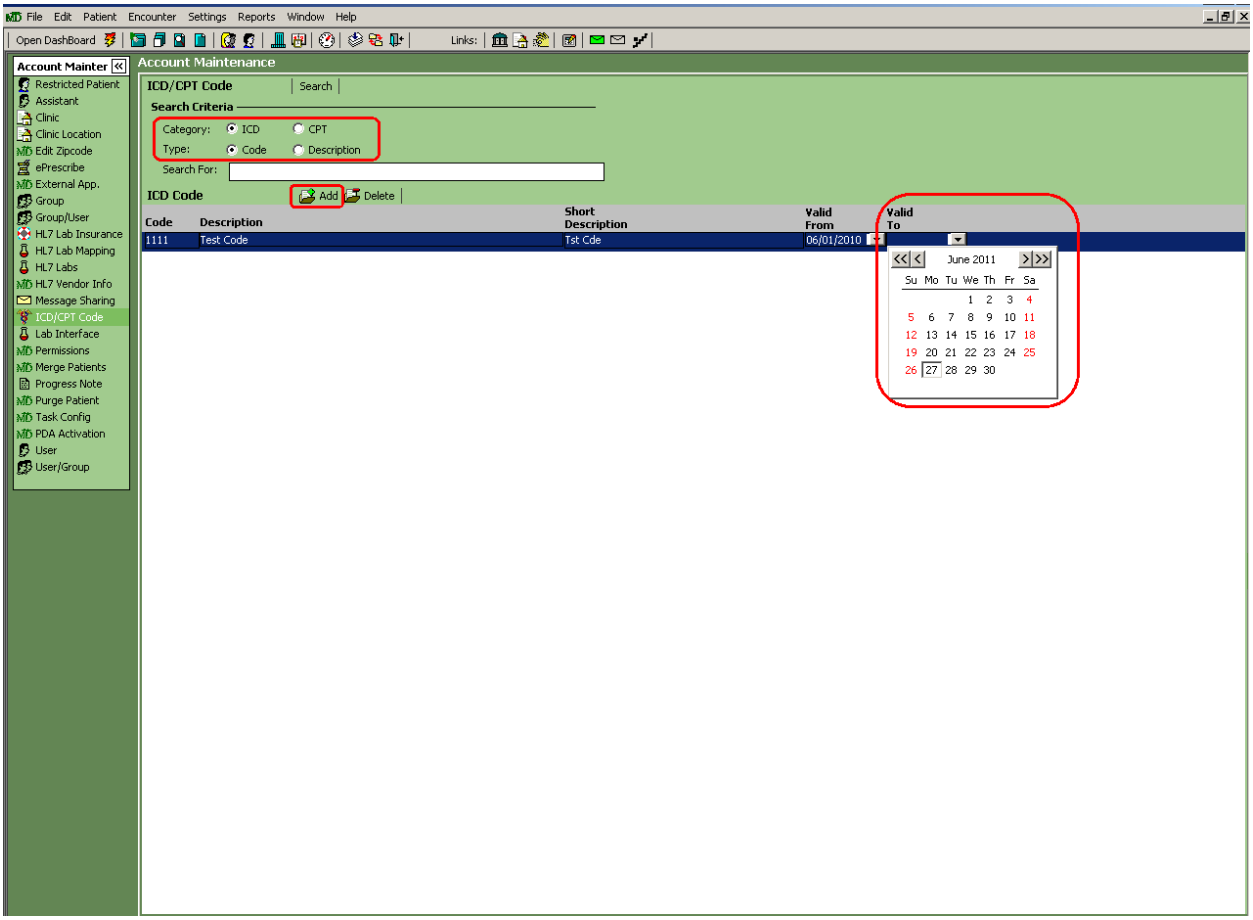
12. ICD/CPT CODE

The 'ICD/CPT Code' tab is used to add ICD/CPT codes to your database if not already included (this is where you can enter custom codes/delete invalid codes). You can also set/modify a code's valid dates.



To add an ICD code or CPT code, follow the steps outlined below:

a. Select *Settings->Account Maintenance->ICD/CPT Code.*
b. **Category:** Select either the ICD or CPT code radio button
c. Click the **Add** button
d. Enter the desired code in the **Code** field, enter a brief code description in the **Description** field and also a **Short Description** in the respective field (this is necessary to view the description if viewing from a PDA or a mobile phone).
e. Set the codes **"Valid From"** and **"Valid To"** dates using the drop-down calendar tool.
f. Click "F5" to save your changes.

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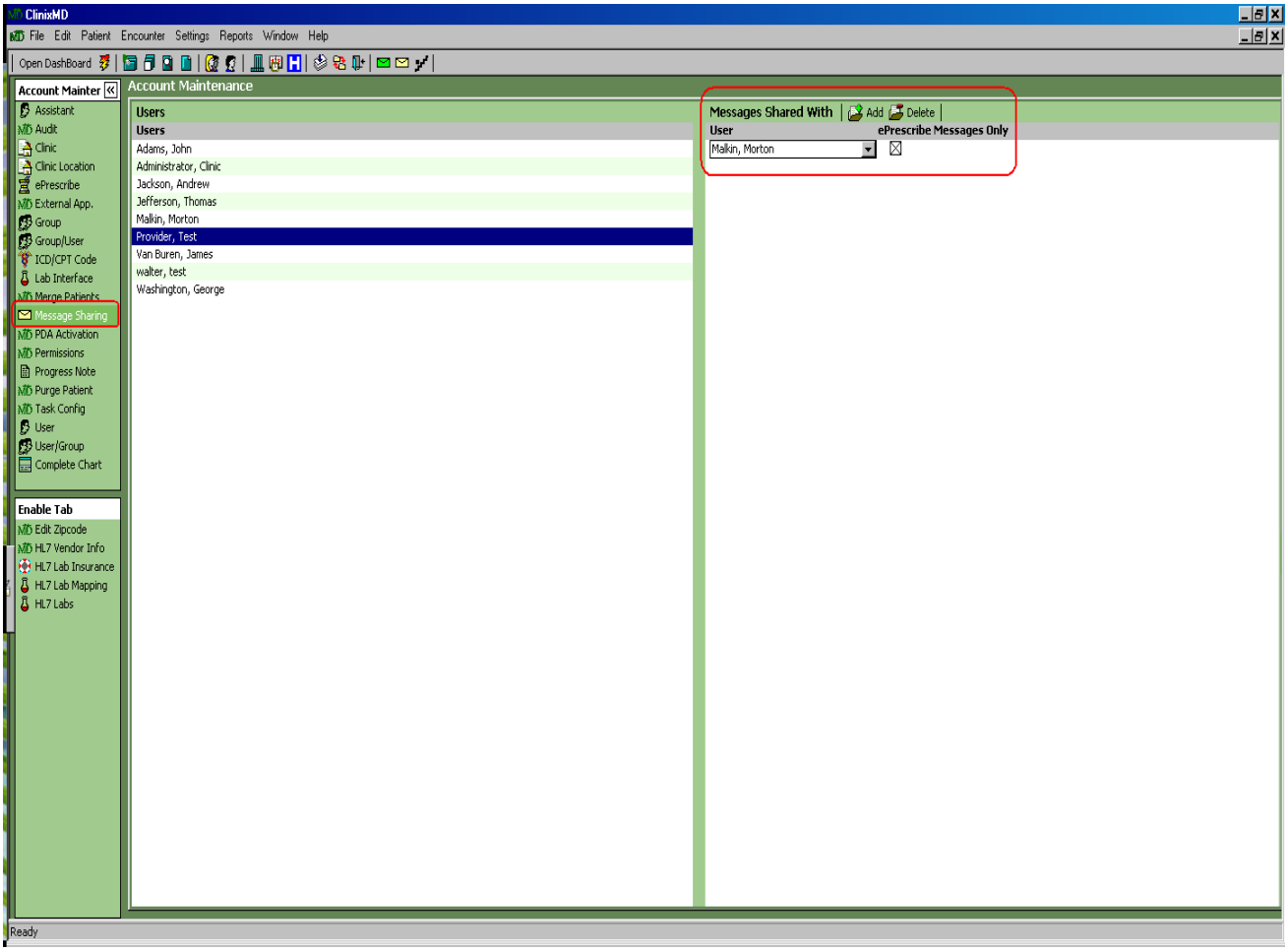
13. MESSAGE SHARING

The 'Message Sharing' tab allows users, typically providers, to share either all or only ePrescribe messages with ancillary users.



To share messages with users, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Message Sharing*
b. Select the appropriate user in the "Users" pane.
c. In the "Message Shared With" pane, click the "Add" button.
d. Select the user that you wish to share messages with from the drop-down list.
e. Mark the "ePrescribe Messages Only" box if you only want to share ePrescribe Refill Messages.
f. Repeat steps *b-e* to share messages with multiple users.

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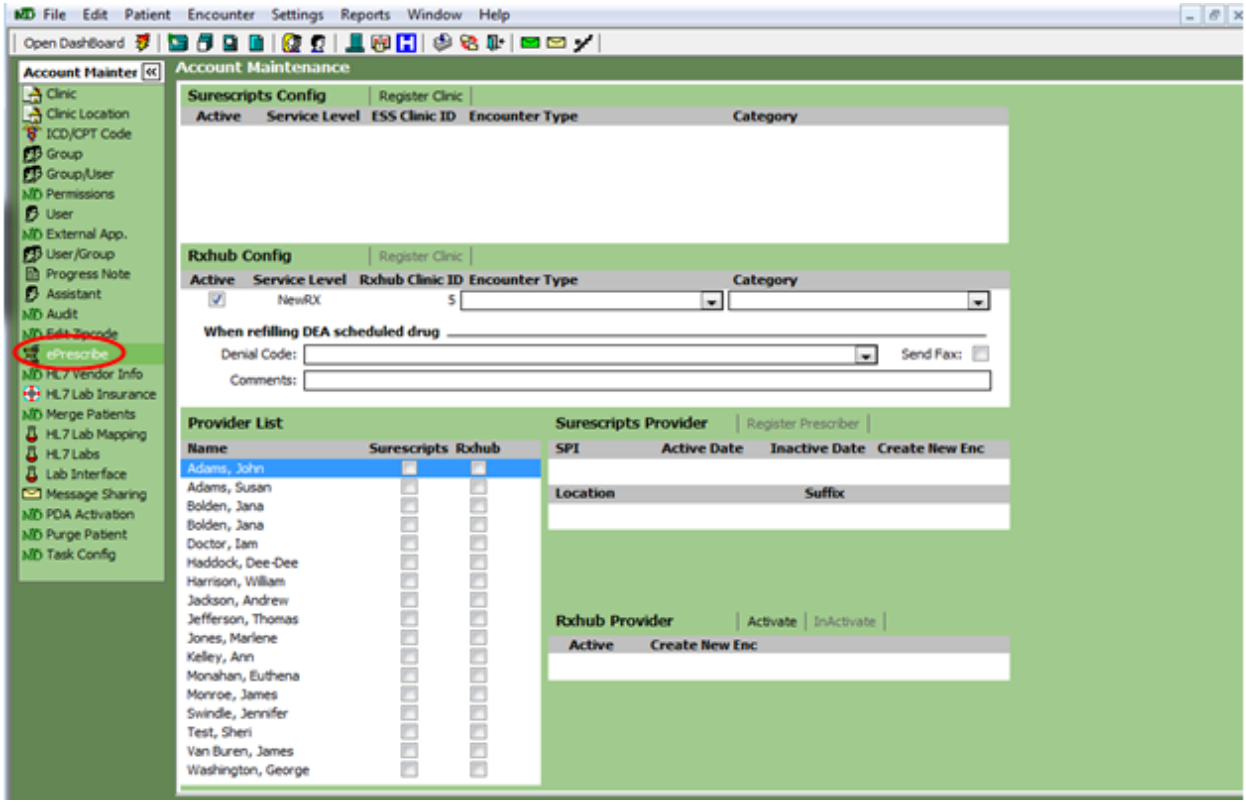
14. ePRESCRIBE

The 'ePrescribe tab' is used to register the clinic and providers with SureScripts to enable ePrescribing.



To register the clinic and providers with SureScripts for ePrescribing, follow the steps outlined below:

a. Select *Settings->Account Maintenance->ePrescribe.*
b. Click the **Register Clinic** button located to the right of **Surescripts Config** to register the practice.
c. Select the default **Encounter Type** from the drop-down list to be used when approving ePrescribe refill messages.
d. Select the default **DEA Denial Code** from the drop-down list to be used when denying ePrescribe refill requests for scheduled drugs. Additional information can be entered in the free-text **Comments** field.
e. Select the provider name from the **Provider List** and click the **Register Prescriber** button.
f. Mark the **Create New Enc** checkbox.
g. To activate the clinic for RX Hub (for mail order ePrescribing as well as to turn on the formulary functionality), click the **Register Clinic** button located to the right of **Rxhub Config**.
h. Highlight the provider name from the **Provider List** and click the **Activate** button.
i. Mark the **Create New Enc** checkbox.

***NOTE - It takes approx. 5 days to register a clinic to ePrescribe. If the provider has ever sent prescriptions electronically with another EHR vendor, a Vendor Release Request will need to be processed by Surescripts; this process takes 48 hours to complete.**

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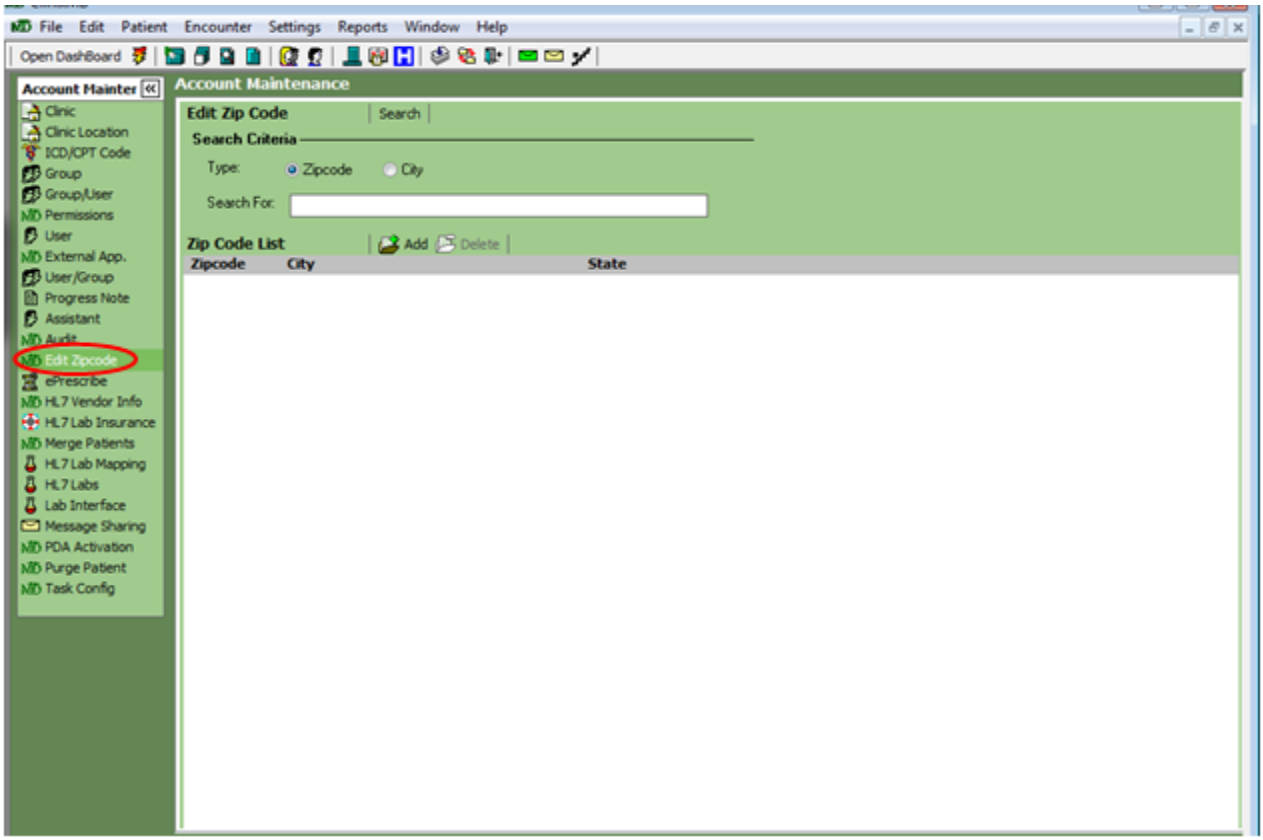
This address MUST match the address, phone and fax number that is found on your clinic's prescription pads.

15. EDIT ZIPCODE

The 'Edit Zipcode' tab is used to search for a city by Zipcode or City and add or amend as needed.



To perform these search functions, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Edit Zipcode*
b. Select the *Radio* button for the Zipcode or City.
c. Enter partial or complete information in the Search fields (zipcode or city).
d. Click the **Search** button to begin the search. A list of results display.
e. **Add, Delete** or **Modify** search results as needed.

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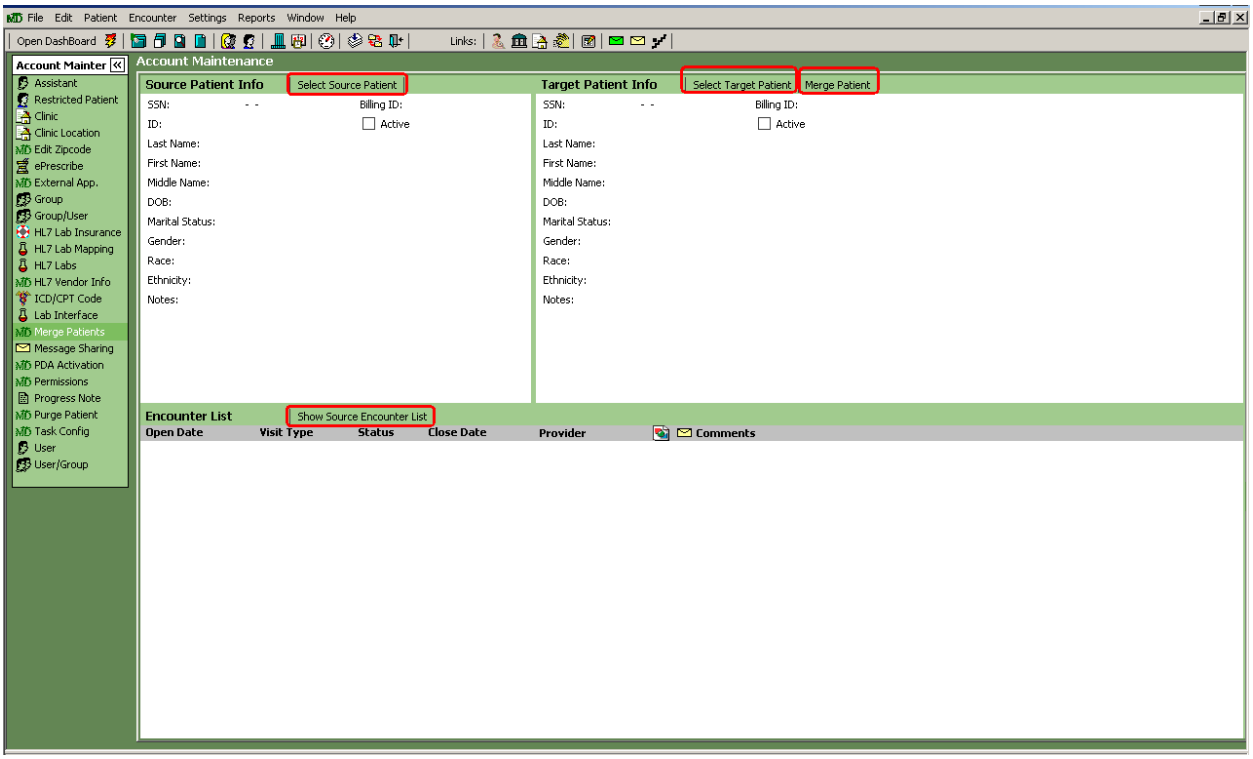
16. MERGE PATIENTS

The 'Merge Patients' tab is used to merge duplicate patient records (Note: Once this action is performed, it cannot be undone).



To Merge Patients, follow the instructions outlined below:

a. Click the **Select Source Patient** button located to the right of **Source Patient Info** to search for and select the duplicate patient.
b. Click the **Select Target Patient** button located to the right of **Target Patient Info** to search for and select the correct patient account (the source patient is merged into the target patient).
c. Click the **Merge Patient** button to process the merge.
d. Click **OK** in the confirmation pop-up box to confirm the merge.

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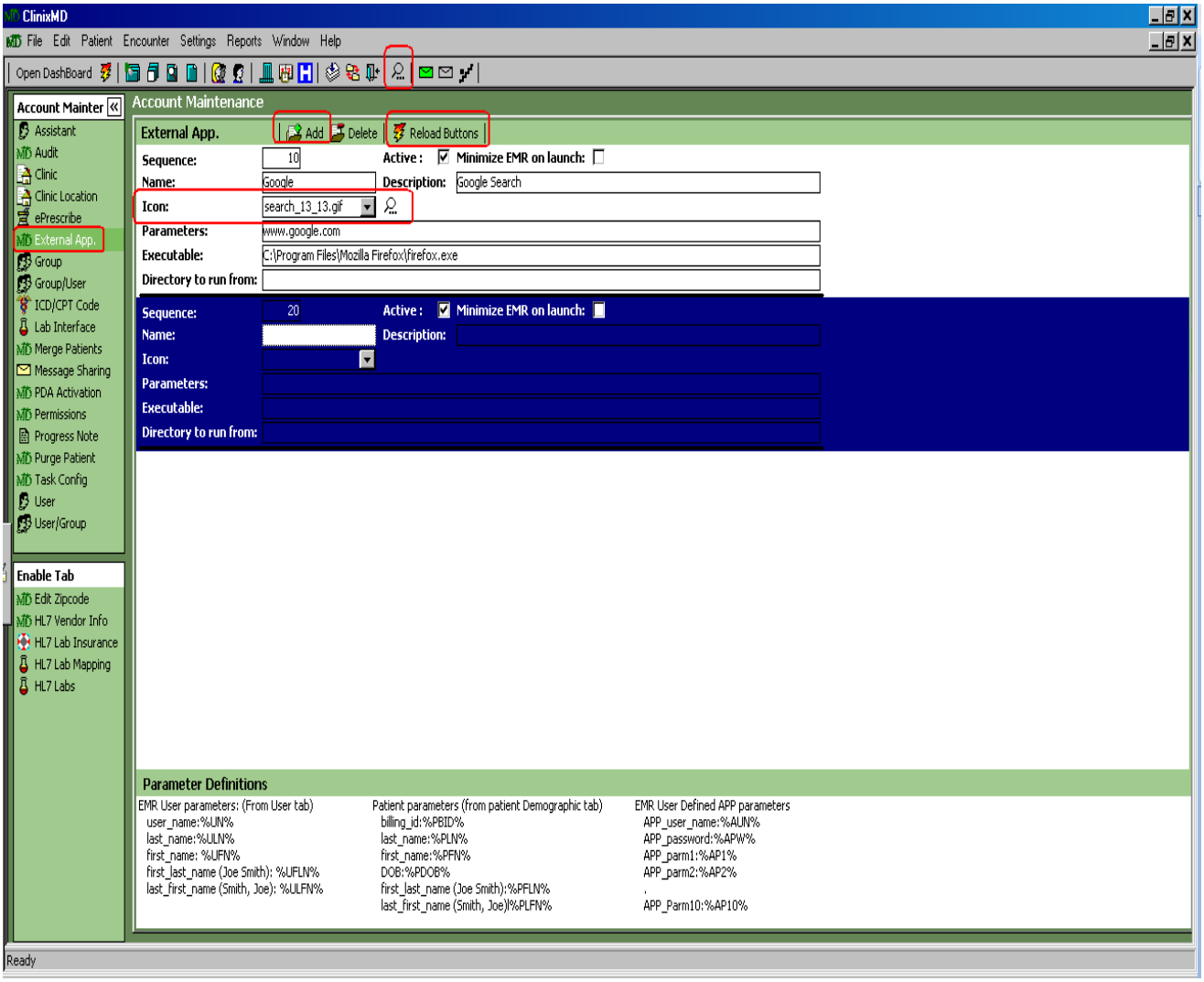
17. EXTERNAL APP.

The 'External App' tab is used to create links to external applications or websites (i.e. Google) within ClinixMD. The icon will be placed in the user's links.



To add a link, follow the steps outlined below:

e. Click the "**Add**" button, located to the right of **External App**.
f. Fill in the applicable criteria, including the application or website Name, Description, Parameters (i.e. the website's URL or the application's UserID, Password, etc.) and the file location for the application or internet browser in the Executable field.
g. Select an icon that is not currently being used (i.e. the magnifying glass).
h. Click the "**Reload Buttons"** button to display the newly added icons to your ClinixMD Toolbar.

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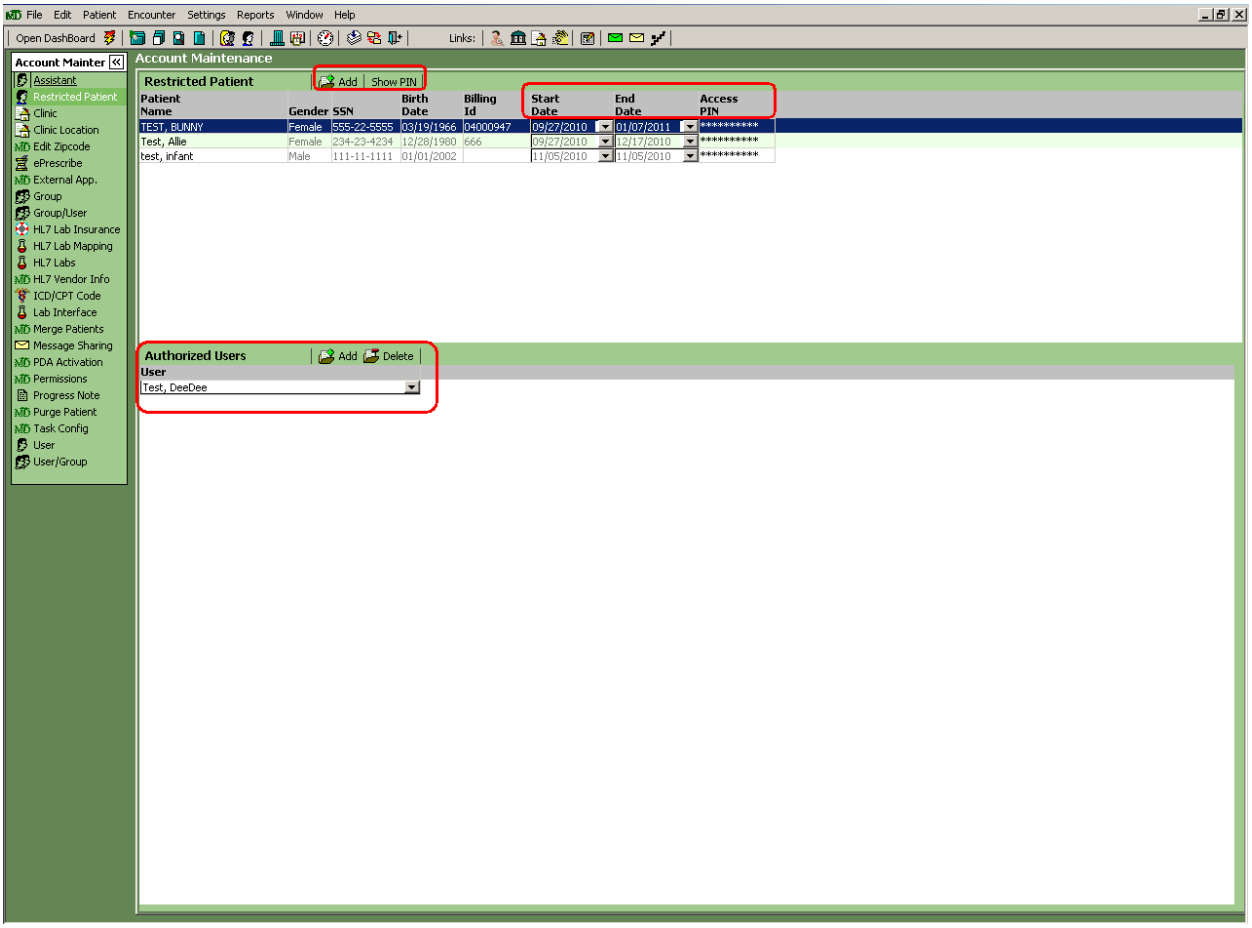
18. RESTRICTED PATIENT

The 'Restricted Patient' tab is to be used for patients with sensitive information that only specified users should be able to access (i.e. clinic employees that are also patients, celebrity patients, etc.). Authorized users can be defined so that they will be able to access these patients information without restriction; all other users will be required to enter the access PIN as well as the reason for accessing the chart. This information is logged in the "Audit Report" in the Reports menu.



To add a Restricted Access Patient, follow the steps outlined below:

a. Click the "**Add**" button, located to the right of **Restricted Patient**.
b. Search for and select the patient in the "Select Patient" search window.
c. By default, the **Start Date** will be the current date; however, this can be changed using the drop-down calendar tool. If this restriction will be for a limited time, set the appropriate **End Date** using the drop-down calendar tool. If the **End Date** is unknown, skip this field.
d. Enter an **Access PIN** in the free text box; this can be any combination of letters and numbers. Ensure that this PIN cannot be easily guessed by others to ensure security of the data. However, if the PIN is forgotten or misplaced, a system administrator can click the "**Show Pin**" button to view the **Access PIN**.

To add an Authorized User, follow the steps outlined below:

a. In the lower pane, click the "**Add**" button, located to the right of **Authorized Users.**
b. Select the authorized user from the drop-down list.
c. To remove a user, select the user in the **Authorized Users** pane and click the "**Delete**" button.

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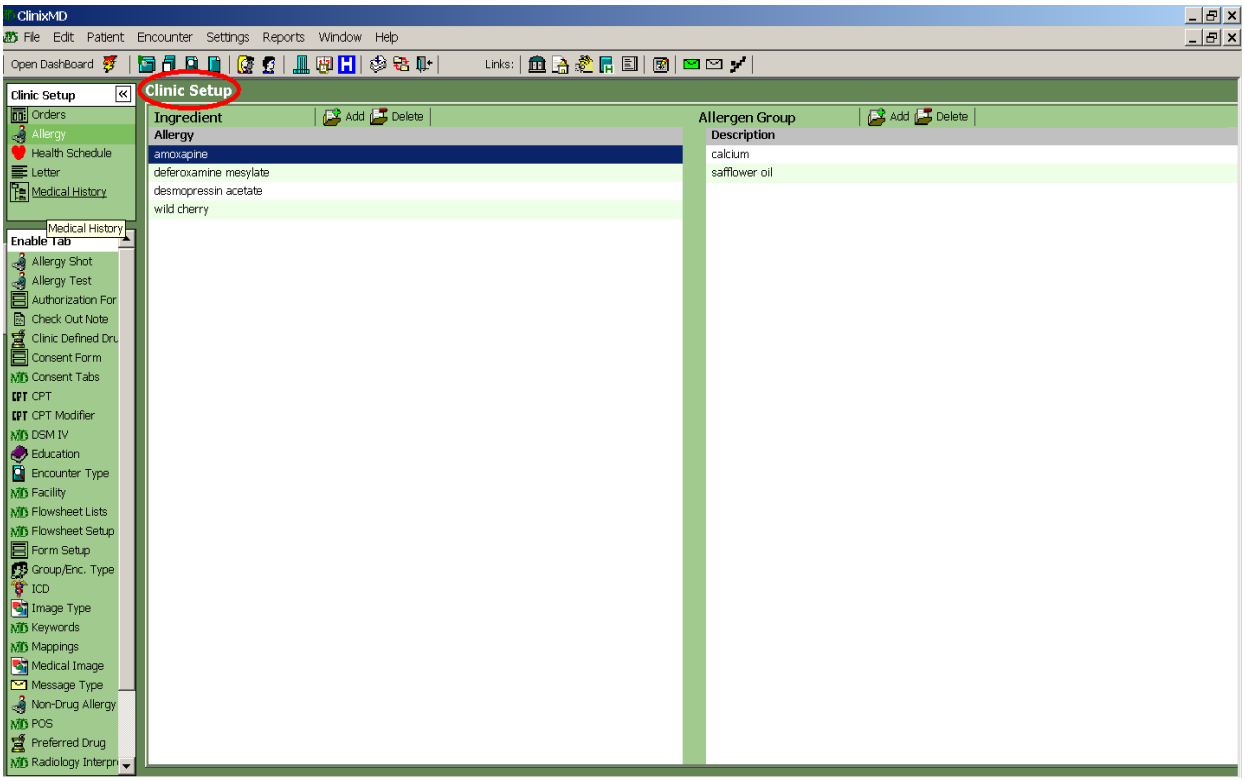
CLINIC SETUP

The 'Clinic Setup' window is used to configure the information that will be used by the clinic personnel. This section is instrumental in facilitating the common tasks performed by staff members. This section will cover all the tabs that make up the Clinic Setup window.



The tabs consist of the following:

1. ICD
2. CPT
3. Allergy
4. Non-Drug Allergy
5. Preferred Drug
6. Clinic Defined Drug
7. Encounter Type
8. Medical History
9. ROS
10. Orders
11. Health Schedule
12. Image Type
13. Medical Image
14. Education
15. Letters
16. Keywords
17. POS
18. Check Out Note
19. CPT Modifier
20. Authorization Form
21. Consent Form
22. Flowsheet Setup
23. Flowsheet Lists
24. DSM IV
25. Message Type
26. Disclosure Text
27. Substance Abuse
28. Decision Support
29. Contact Type
30. Radiology Result
31. Radiology Interpretation
32. Facility
33. Workflow

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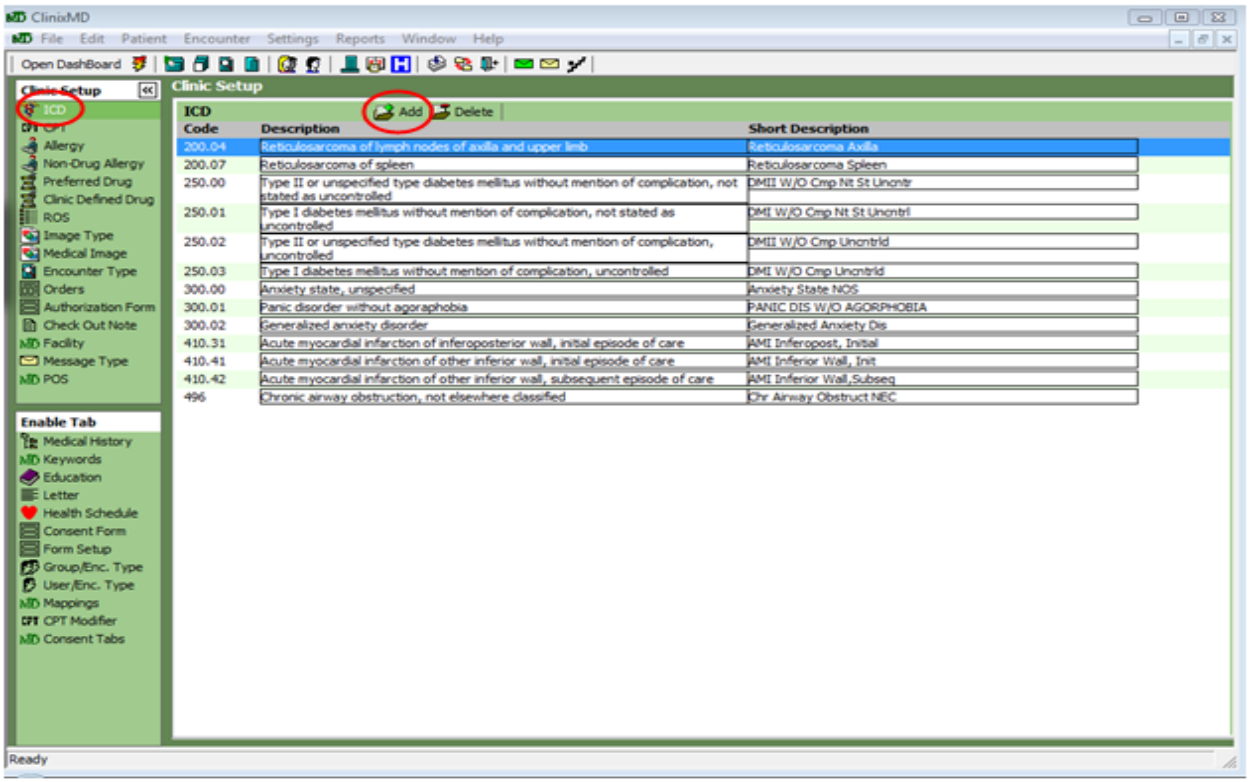
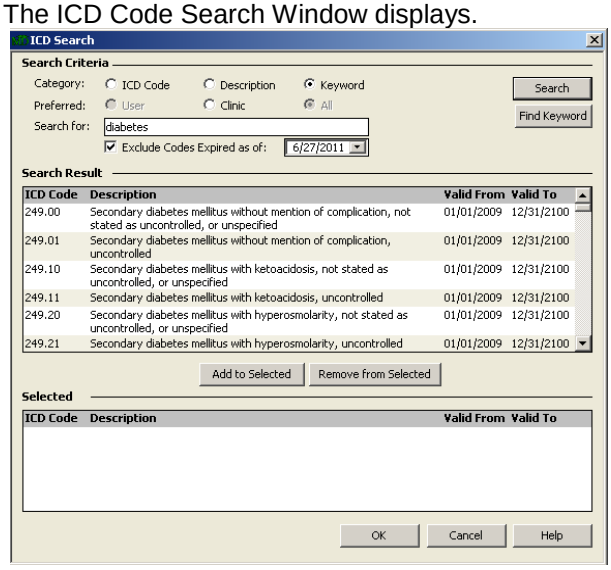
1. ICD

The 'ICD' tab is used to create a standardized list of common choices for the clinic. After the administrator sets up this list, it then becomes available to the entire clinic. When a staff member uses the ICD Code Search window, the clinic preferred list displays only those items chosen by the administrator. This eliminates the need to search the entire database of ICD codes for the items most often used by the clinic.


ClinixMD
File Edit Patient Encounter Settings Reports Window Help
Open DashBoard
Clinic Setup
ICD
Add
Delete
Code
Description
Short Description
200.04 Reticulosarcoma of lymph nodes of axilla and upper limb Reticulosarcoma Axilla
200.07 Reticulosarcoma of spleen Reticulosarcoma Spleen
250.00 Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled DMII W/O Cmp Nt St Uncntr
250.01 Type I diabetes mellitus without mention of complication, not stated as uncontrolled DMI W/O Cmp Nt St Uncntrl
250.02 Type II or unspecified type diabetes mellitus without mention of complication, uncontrolled DMII W/O Cmp Uncntrld
250.03 Type I diabetes mellitus without mention of complication, uncontrolled DMI W/O Cmp Uncntrld
300.00 Anxiety state, unspecified Anxiety State NOS
300.01 Panic disorder without agoraphobia PANIC DIS W/O AGORPHOBIA
300.02 Generalized anxiety disorder Generalized Anxiety Dis
410.31 Acute myocardial infarction of inferoposterior wall, initial episode of care AMI Inferopost, Initial
410.41 Acute myocardial infarction of other inferior wall, initial episode of care AMI Inferior Wall, Init
410.42 Acute myocardial infarction of other inferior wall, subsequent episode of care AMI Inferior Wall,Subseq
496 Chronic airway obstruction, not elsewhere classified Chr Airway Obstruct NEC
Allergy
Non-Drug Allergy
Preferred Drug
Clinic Defined Drug
ROS
Image Type
Medical Image
Encounter Type
Orders
Authorization Form
Check Out Note
Facility
Message Type
POS
Enable Tab
Medical History
Keywords
Education
Letter
Health Schedule
Consent Form
Form Setup
Group/Enc. Type
User/Enc. Type
Mappings
CPT Modifier
Consent Tabs
Ready

To add an ICD code to the clinic list, follow the steps outlined below:

a. Select *Settings->Clinic Setup->ICD.*
b. From the ICD Tab, click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. The ICD Code Search Window displays.


ICD Search
Search Criteria
Category: ICD Code Description Keyword
Preferred: User Clinic All
Search for: diabetes
Exclude Codes Expired as of: 6/27/2011
Search
Find Keyword
Search Result
ICD Code Description Valid From Valid To
249.00 Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.01 Secondary diabetes mellitus without mention of complication, uncontrolled 01/01/2009 12/31/2100
249.10 Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.11 Secondary diabetes mellitus with ketoacidosis, uncontrolled 01/01/2009 12/31/2100
249.20 Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.21 Secondary diabetes mellitus with hyperosmolarity, uncontrolled 01/01/2009 12/31/2100
Add to Selected
Remove from Selected
Selected
ICD Code Description Valid From Valid To
OK
Cancel
Help

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c. Enter partial or complete information in the ICD code, description or keyword field (Click on the radio button next to the label to select either “ICD Code,” “Description” or “Keyword”)
d. Select the “All” preferred list radio button.
e. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.
f. Click the **Search** button to display a list in the Search Results pane.
g. Highlight your Select*ion* from the list and click the **Add to** Selected button or double-click the selection to populate the appropriate tab with your choice. Multiple selections can be added to the selected list.
h. Click the *OK* button to complete the selection process. The item or items will appear in the tab you are working with.

To remove an ICD code, follow the steps outlined below:

a. Select *Settings->Clinic Setup->ICD.*
b. From the ICD tab, highlight the *ICD* code you wish to delete from the Clinic List.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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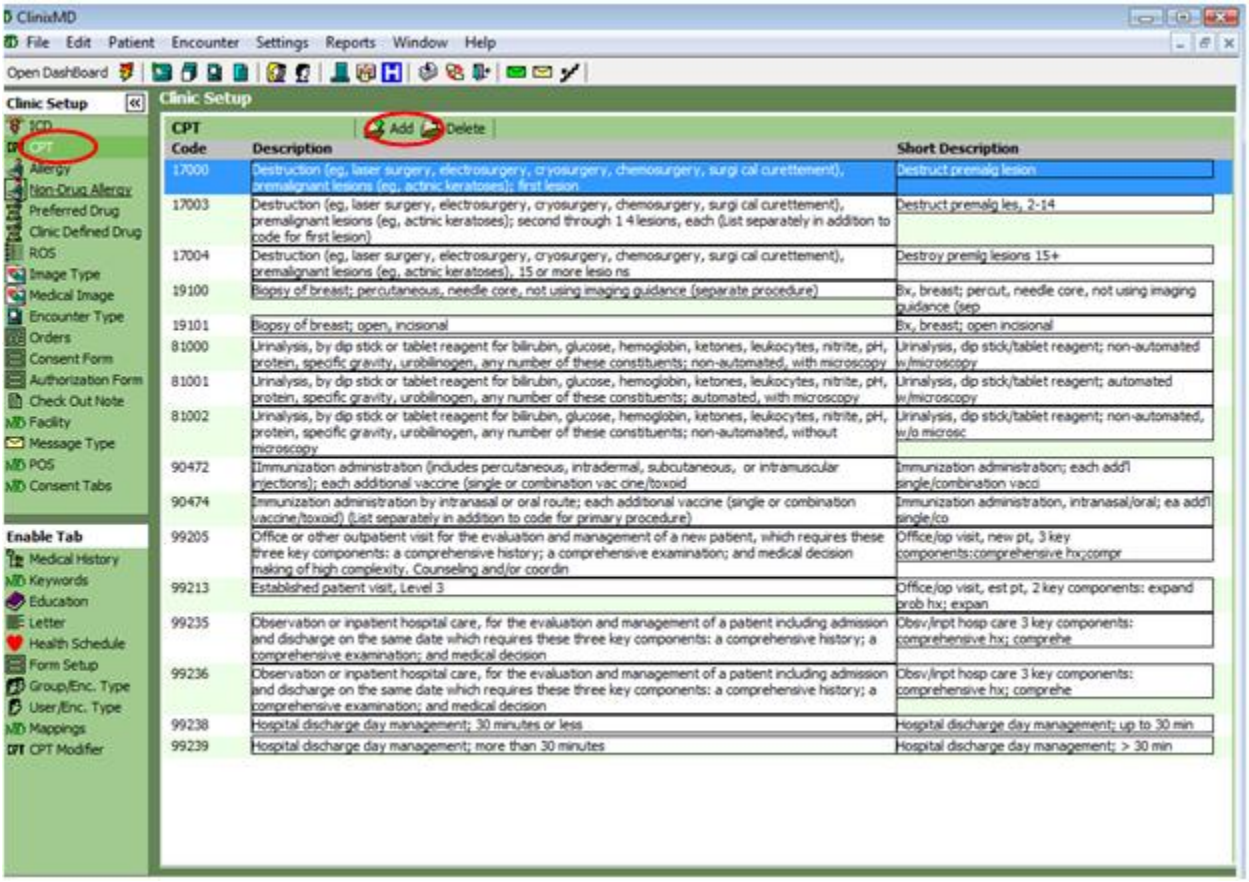
2. CPT

The 'CPT' Code tab is used to create a standardized list of common choices for the clinic. After the administrator sets up this list, it then becomes available to the entire clinic. Customizing this list eliminates the need to search the entire database of CPT codes for the items most often used by the clinic.


ClinixMD
File Edit Patient Encounter Settings Reports Window Help
Open DashBoard
Clinic Setup
ICD
CPT
Allergy
Non-Drug Allergy
Preferred Drug
Clinic Defined Drug
ROS
Image Type
Medical Image
Encounter Type
Orders
Consent Form
Authorization Form
Check Out Note
Facility
Message Type
POS
Consent Tabs
Enable Tab
Medical History
Keywords
Education
Letter
Health Schedule
Form Setup
Group/Enc. Type
User/Enc. Type
Mappings
CPT Modifier
Clinic Setup
CPT
Add
Delete
Code
Description
Short Description
17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgi cal curettement), premalignant lesions (eg, actinic keratoses); first lesion — Destruct premalg lesion
17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgi cal curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) — Destruct premalg les, 2-14
17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgi cal curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesio ns — Destroy premlg lesions 15+
19100 Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) — Bx, breast; percut, needle core, not using imaging guidance (sep
19101 Biopsy of breast; open, incisional — Bx, breast; open incisional
81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy — Urinalysis, dip stick/tablet reagent; non-automated w/microscopy
81001 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy — Urinalysis, dip stick/tablet reagent; automated w/microscopy
81002 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy — Urinalysis, dip stick/tablet reagent; non-automated, w/o microsc
90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vac cine/toxoid — Immunization administration; each add'l single/combination vacci
90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) — Immunization administration, intranasal/oral; ea add'l single/co
99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordin — Office/op visit, new pt, 3 key components:comprehensive hx;compr
99213 Established patient visit, Level 3 — Office/op visit, est pt, 2 key components: expand prob hx; expan
99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision — Obsv/inpt hosp care 3 key components: comprehensive hx; comprehe
99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision — Obsv/inpt hosp care 3 key components: comprehensive hx; comprehe
99238 Hospital discharge day management; 30 minutes or less — Hospital discharge day management; up to 30 min
99239 Hospital discharge day management; more than 30 minutes — Hospital discharge day management; > 30 min

To add codes to the CPT list, follow the steps outlined below:

a. Select *Settings->Clinic Setup->CPT*
b. Click the **Add** button located to the right of **CPT**. The "CPT Search" window displays as shown below:

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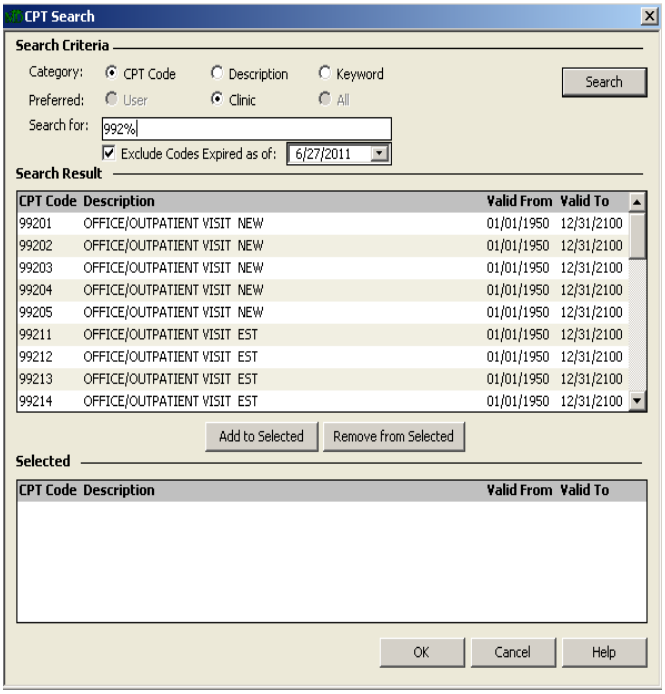
CPT Search
Search Criteria
Category: CPT Code Description Keyword
Preferred: User Clinic All
Search for: 992%
Exclude Codes Expired as of: 6/27/2011
Search
Search Result
CPT Code Description Valid From Valid To
99201 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99202 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99203 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99204 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99205 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99211 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99212 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99213 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99214 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
Add to Selected
Remove from Selected
Selected
CPT Code Description Valid From Valid To
OK
Cancel
Help

c. Use the radio buttons to select the search criteria you wish to use in performing your search. Options are: CPT Code, Description or Keyword.
d. Enter partial or complete information in the search field you selected.
e. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.
f. Click the **Search** button. A list of results appears in the *Search* Results pane.
g. Select one or more *CPT Codes* from the results pane and click the **Add to Selected** button.
h. If you wish to remove a code from the selected list, highlight that code and click the **Remove from** Selected button.
i. Once you have made your selection, click the *OK* button to populate the CPT Code tab with the codes you have selected.

To remove a CPT code from the clinic list, follow the steps outlined below:

a. Select *Settings->Clinic Setup->CPT*
b. From the CPT tab, highlight the *CPT Code* you wish to delete from the clinic list.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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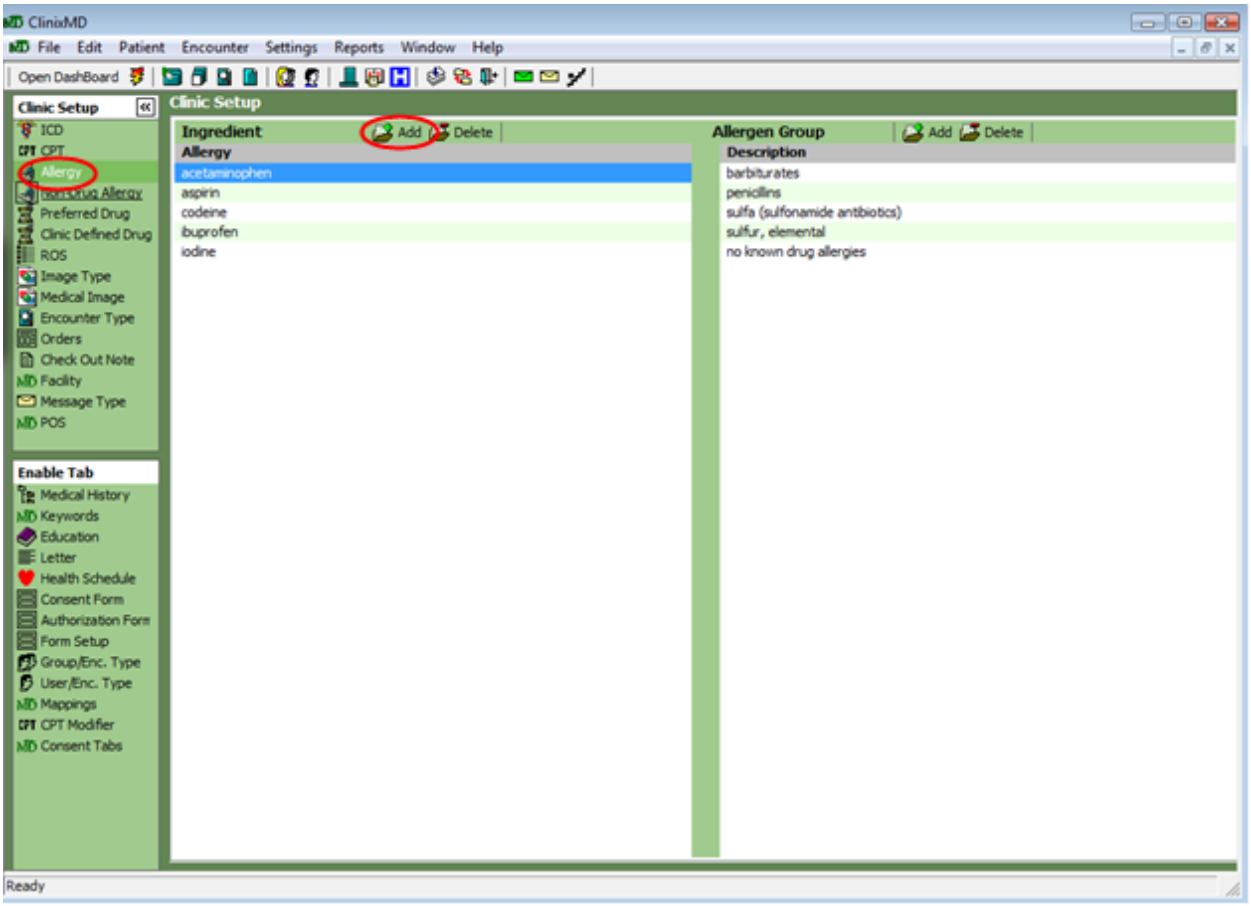
3. ALLERGY

This tab contains the Allergy codes specific to the clinic. The administrator can create a list that includes the most common Allergens Selected by the entire clinic. Once the list is compiled, a user can perform searches and select the Clinic Preferred list to bring up these most commonly used allergens.



To add Allergens to the Allergy tab, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Allergy*
b. **Adding an Allergen Group** - From the 'Allergy' tab in the Clinic Setup window, click the "Add" button and the following screen will appear:

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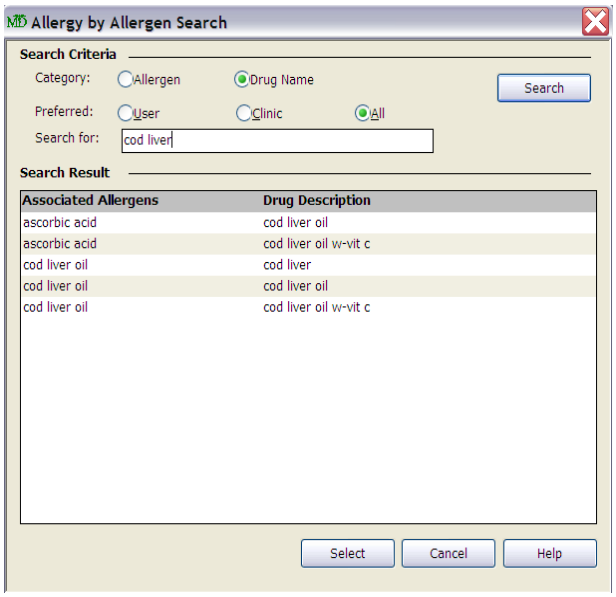
In this example, if the Allergen Group is Penicillins, the user will enter the first three letters of the group and Click **Search**. When the Group is Highlighted, Click Select to bring it into the Clinic's preferred list.

To add an allergy to an Ingredient, follow the steps outline below:

c. Select *Settings->Clinic Setup->Allergy*.
d. **Adding an Ingredient** - from the Allergy Code tab in the Clinic Setup window, click the "Add" button and the following screen will appear:



In this example, if the Allergen Ingredient is Cod Liver Oil, the user will enter the first three letters of the group, and Click **Search**. When the Ingredient is highlighted, click "Select" to bring it into the Clinic's preferred list.

To delete an Allergen from the from the Allergy tab, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Allergy*.
b. From the Allergy Code tab in the Clinic Setup window, highlight the *Allergy* code you want to delete.
c. Click the **Delete** icon or right-mouse Click and Select **Delete** from the drop-down menu. A confirmation box displays.
d. Confirm your deletion by Clicking *OK*.

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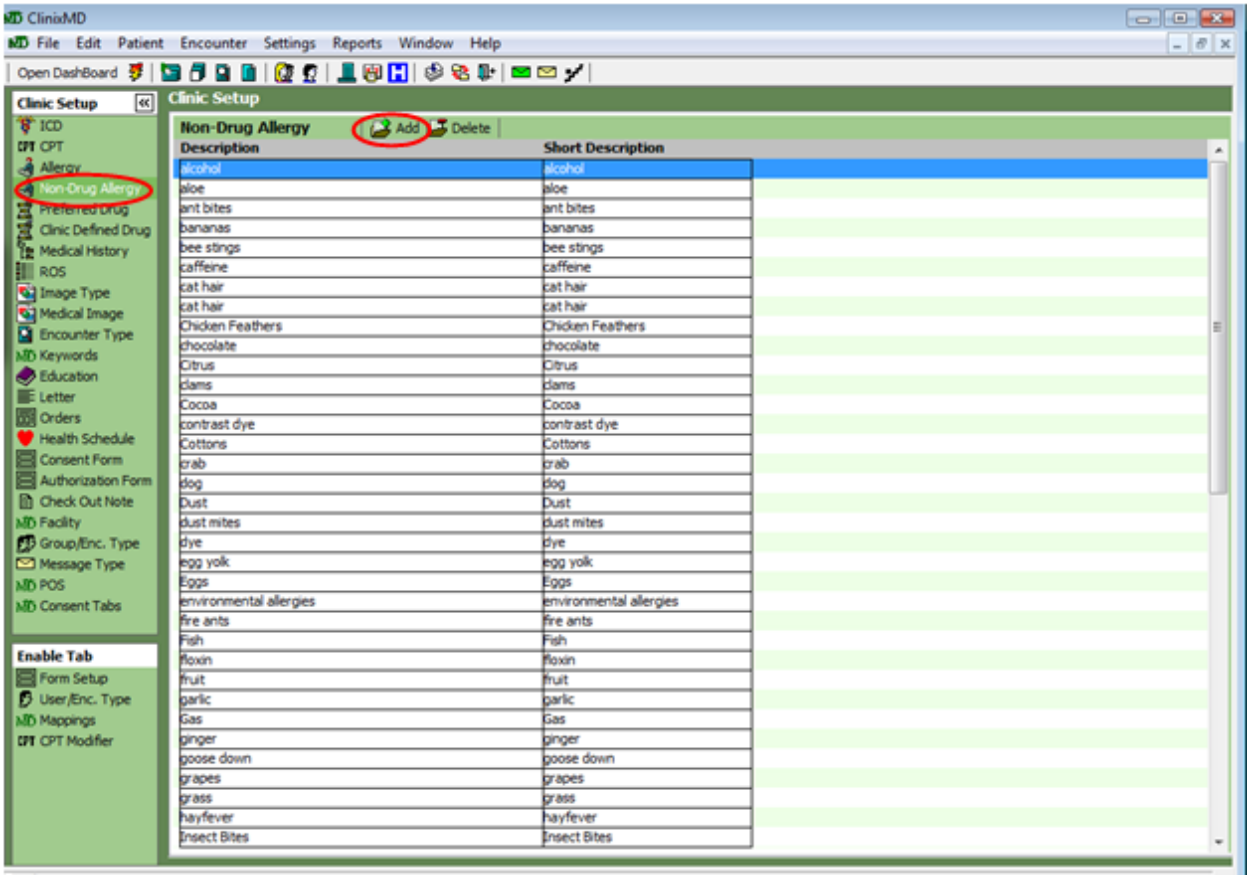
4. NON-DRUG ALLERGY

The 'Non-Drug Allergy' tab allows you to list other allergies that are associated with other factors besides allergens and drug related reactions. For example, this tab can contain allergies to pollen, cat dander or strawberries.



To add a Non-Drug Allergy, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Non-Drug Allergy.*
b. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays.
c. Enter a Description and a Short Description (used for PDA devices) for the allergy you want to add.
d. Repeat the above steps as necessary.

To delete a Non-Drug Allergy, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Non-Drug Allergy.*
b. Click on the *Non-Drug Allergy* you want to delete from the list in the Non-Drug Allergy Tab.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box appears.
d. Confirm your deletion by clicking *OK*.

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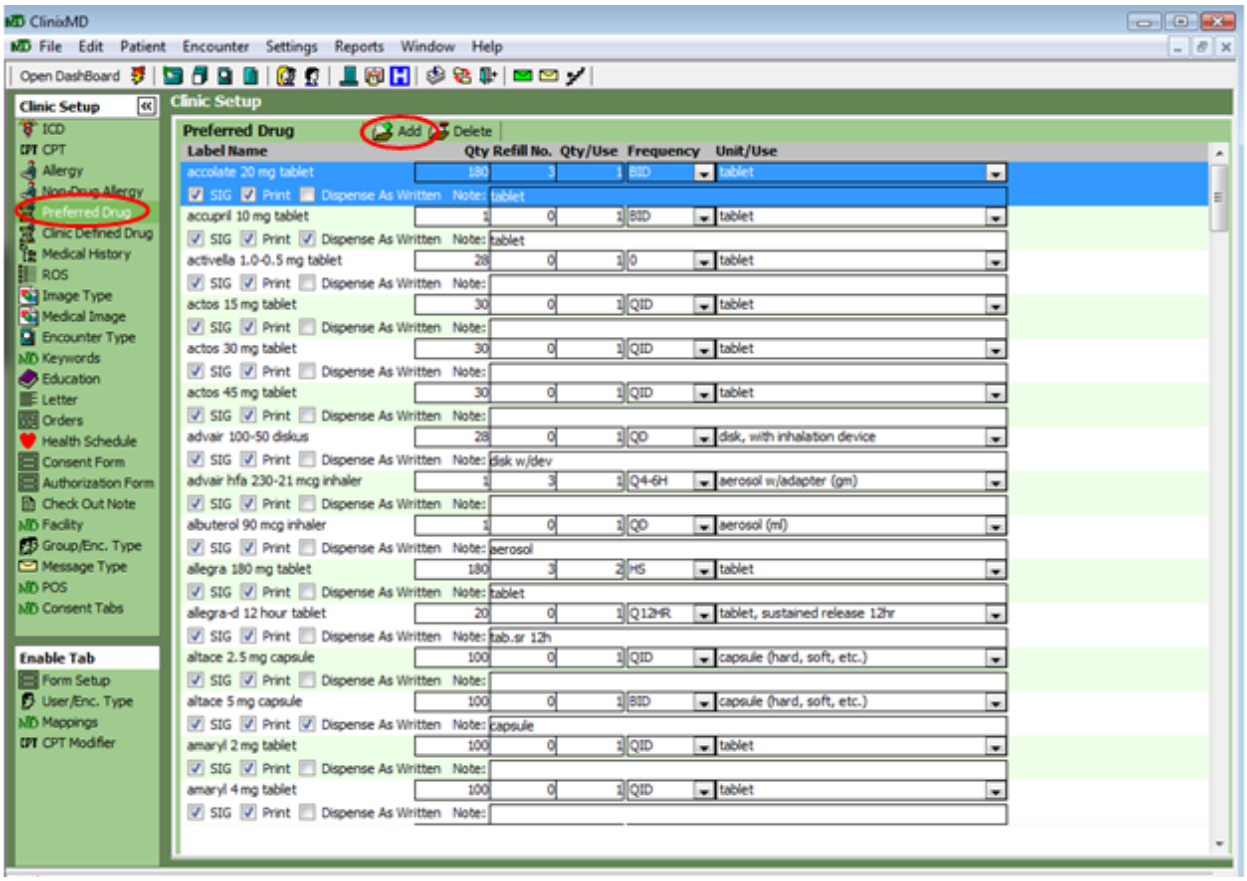
5. PREFERRED DRUG

The 'Preferred Drug' tab in the Clinic Setup window is available to compile a list of commonly prescribed drugs.



It is organized with the following:

- Label Name
- Qty
- Refill
- Qty/Use
- Frequency
- Unit/Use
- SIG
- Print
- Dispense as Written
- Note

The administrator is able to create a clinic specific list of drugs that can be used to perform drug searches in other areas of the ClinixMD application. Once the list is setup, clinic users can easily filter the drug search window to bring up the **Clinic Preferred List** with the items that are most commonly used by the staff.

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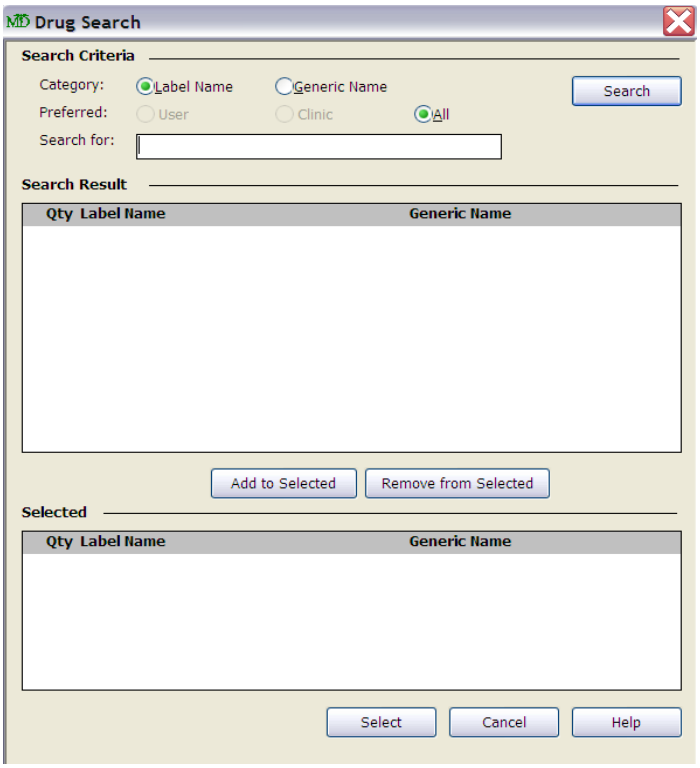
To add a drug to the Preferred Drug tab, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Drug Name.*
b. From the Preferred Drug tab, click the **Add** icon from the toolbar or right-mouse click in the *Preferred Drug* tab and select **Add** from the drop-down menu. The Drug Search window displays as shown below:



c. Use the radio buttons to select the search Criteria you wish to use in performing your search. The options are Label Name or Generic Name.
d. Enter partial or complete information in the search field you selected.
e. Click the **Search** button. A list of results appears in the Search Results pane.
f. Select one or more *Drugs* from the results pane and click the **Add to Selected** button. See example below.

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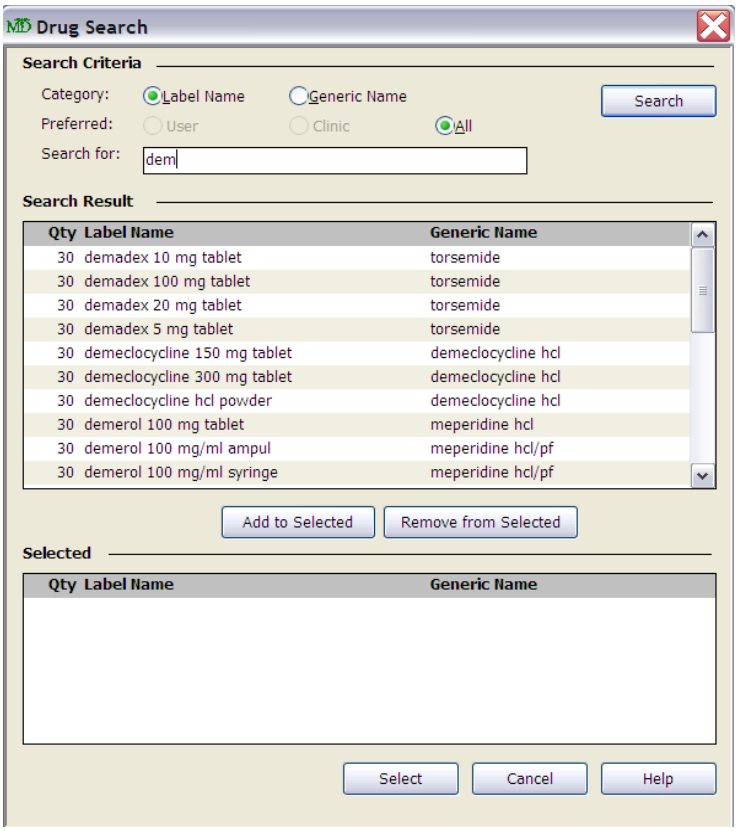

g. If you wish to remove a code from the selected list, highlight that *Drug* and click the **Remove from Selected** button.
h. Once you have made your selection, click the *OK* button to populate the *Preferred Drug* tab with the codes you have selected.
i. Fill in any notes for the drug as needed.

To delete a Preferred Drug, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Preferred Drug.*
b. From the Preferred Drug tab, click the Preferred Drug you want to delete.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box appears.
d. Confirm your deletion by clicking *OK*.

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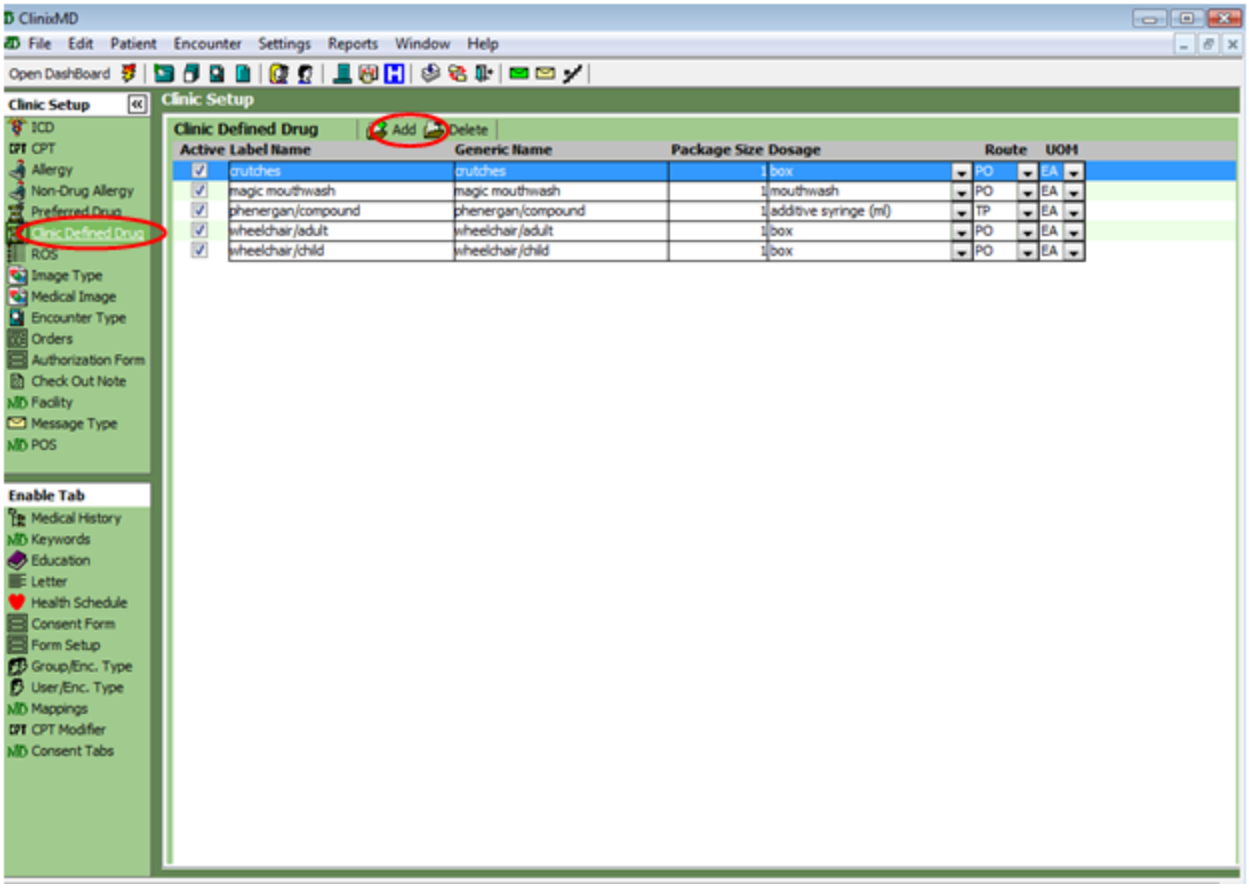
6. CLINIC DEFINED DRUG

The 'Clinic Drug Defined' tab allows the clinic to add drugs, supplies or DME that is otherwise not listed in the drug database.



To add Clinic Drug Defined items, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Clinic Drug Defined.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add**. A new row displays.
c. Enter the Label Name, Generic Name, Package Size, Dosage, Route and UOM.

To delete a Defined Drug, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Drug Defined.*
b. From the Drug Defined tab, highlight the *Defined Drug* you wish to delete from the Clinic List.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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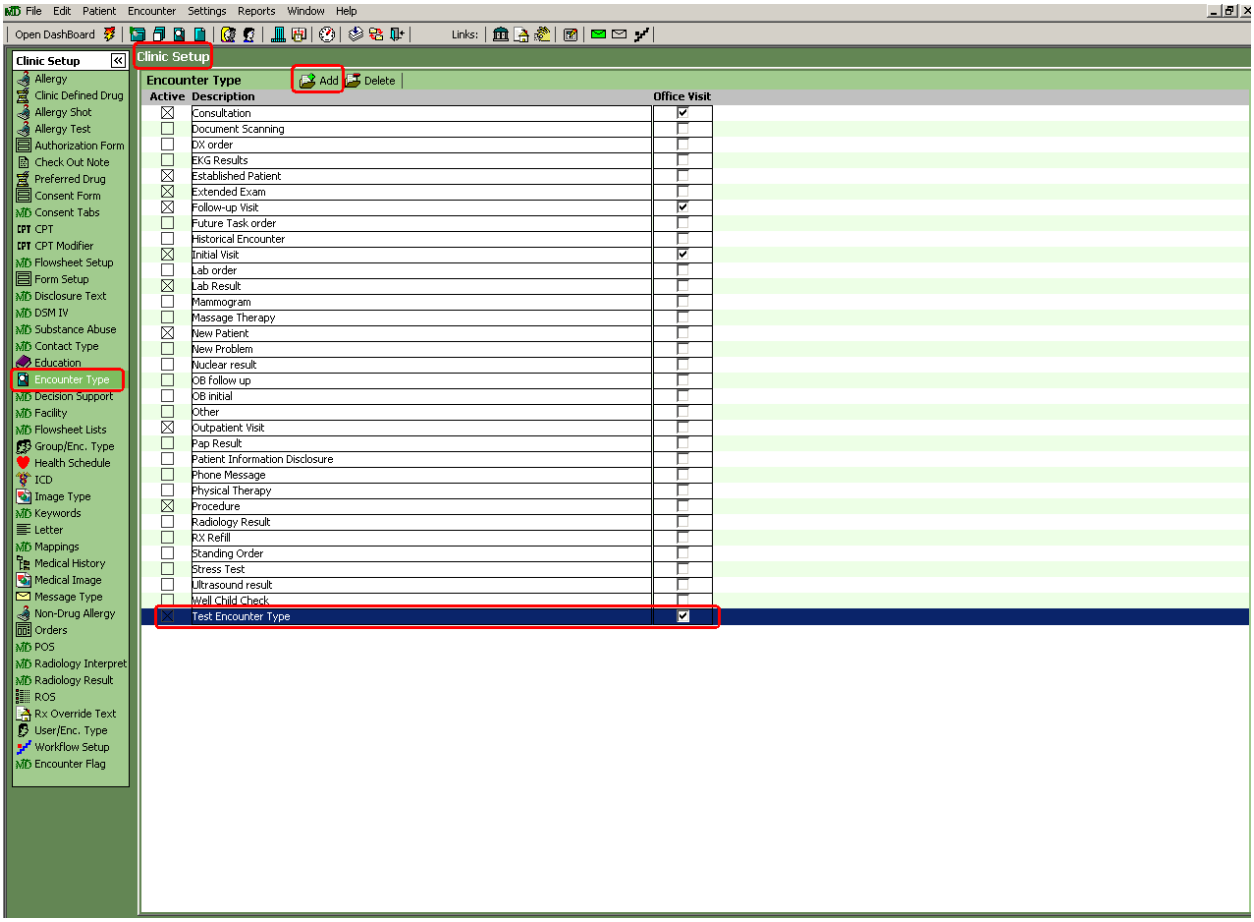
7. ENCOUNTER TYPE

The 'Encounter Type' tab allows the clinic to add specific encounter types for office visits. Also, you will need to mark the "Office Visit" check-box to denote those encounters that are strictly used for patient visits (i.e. not used to scan information into the patient's chart). **Note: *The "Office Visit" setting is mandatory for accurate Meaningful Use Stage 1 reporting.***



To add an Encounter type, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Encounter Type.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add.** A new row displays.
c. Enter the Encounter Type and Description.
d. If this encounter will be strictly used to document a patient visit, mark the "Office Visit" check-box.

Encounter types cannot be deleted if it has been attached to a patient's chart. If you no longer wish to utilize a specific encounter type, uncheck the *Active* box and it will no longer be available to select.

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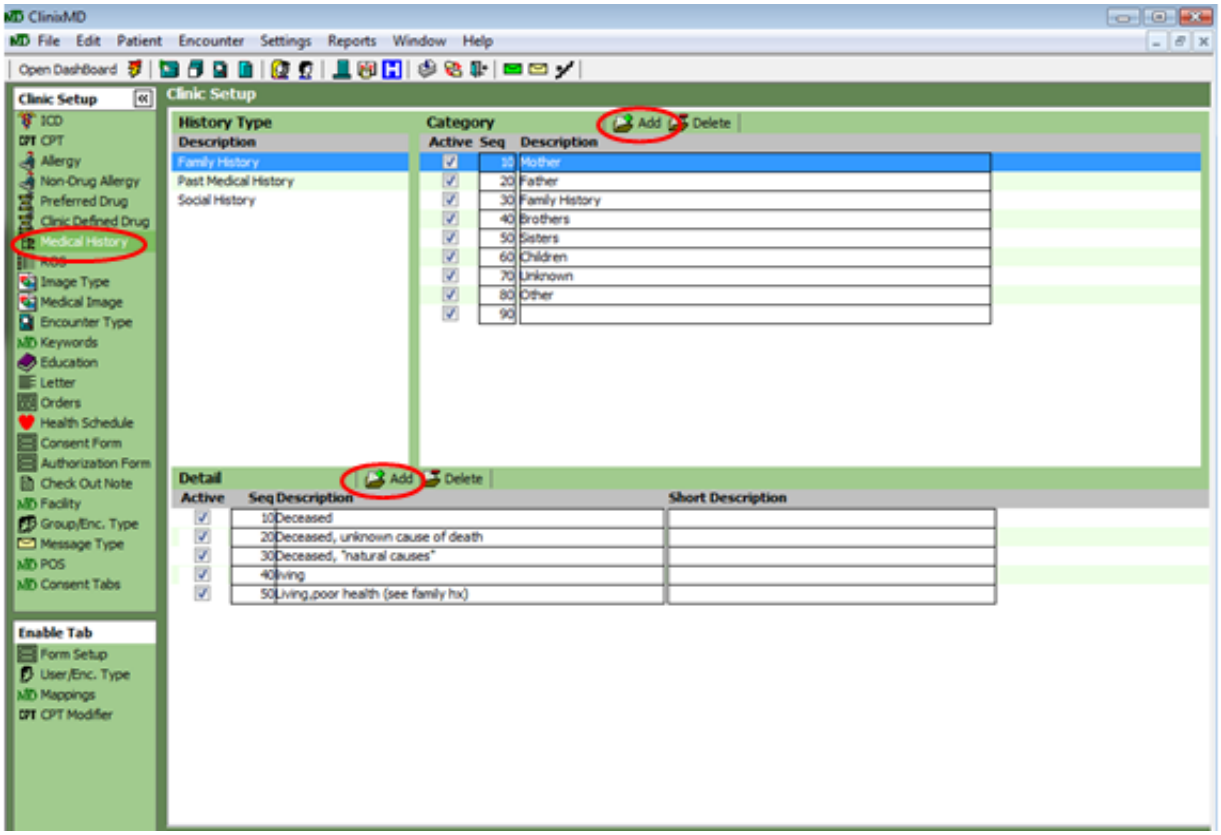
8. MEDICAL HISTORY

The 'Medical History' tab is used to create the choices that will appear in the Medical History section of the Patient Information tab.



This tab is divided into three panes:

- **History Type** – This pane contains three static categories that cannot be changed (Family History, Past Medical History, Social History)
- **Category** – This pane contains a sequence number for each category and a description column.
- **Detail** - This pane contains the description (including a short description column for PDA devices).

These three panes mirror the sections found in the Medical History Tab of the Patient Information window. Once the Medical History is configured in this setup tab, the information becomes available for users to select when building the Medical History information in an encounter.

To configure a Medical History record, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Medical History.*
b. Click the *History Type* you want to configure in the History Type pane.
c. Click in the *Category* pane to activate this area.
d. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row in the Category pane displays.
e. Type in the description in the appropriate column.
f. Click in the *Detail* pane to activate this area.
g. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row in the Detail pane displays.

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h. Fill in the appropriate information for Description and Short description.

To delete Medical History, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Medical History*
b. From the Medical History tab, highlight the *Description* you want to delete from the List pane.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays. This action will delete the Detail as well.
d. Confirm your deletion by clicking *OK.*

Note: The Category and Description panes allow for the sequencing.

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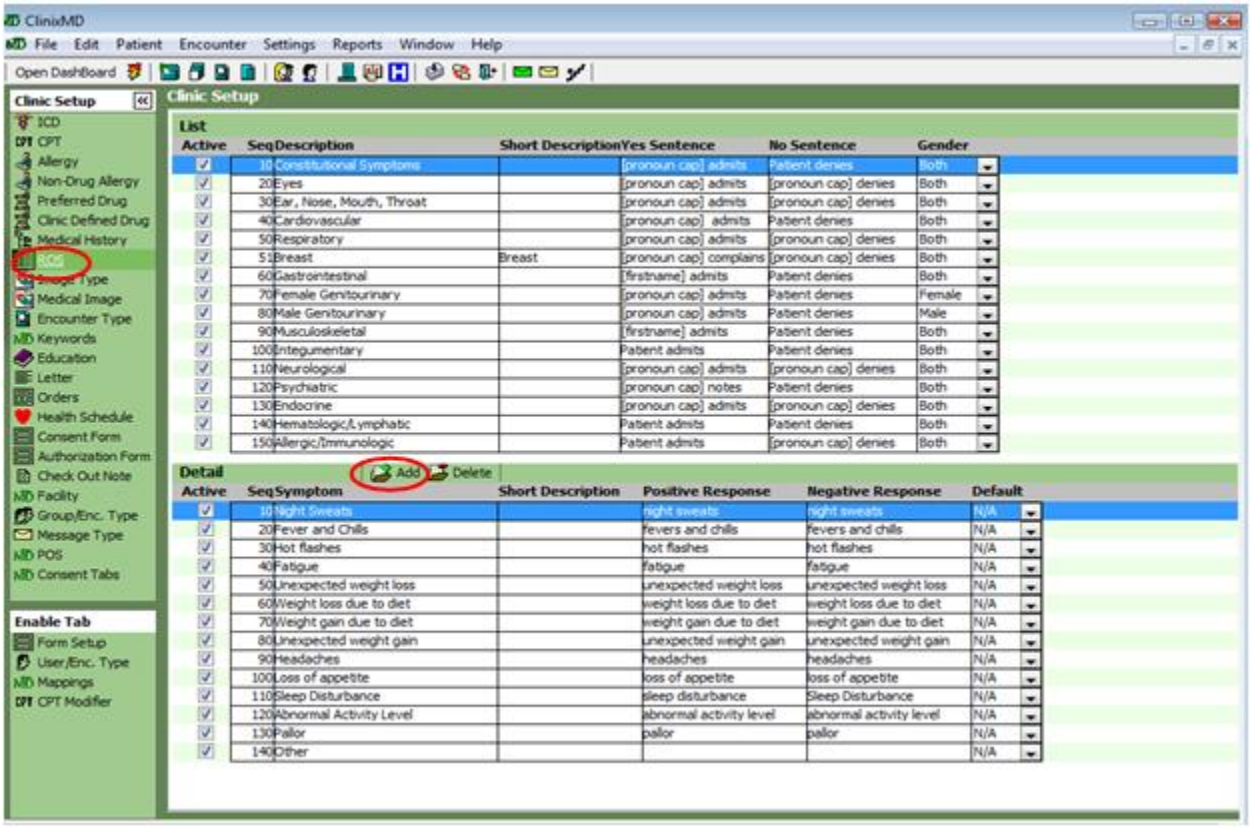
9. ROS (REVIEW OF SYSTEMS)

The 'ROS' Tab is used to setup the Review of Systems information that will appear in the ROS Tab found in the encounter window. This window is divided into two panes.


ClinixMD
File Edit Patient Encounter Settings Reports Window Help
Open DashBoard
Clinic Setup
ICD
CPT
Allergy
Non-Drug Allergy
Preferred Drug
Clinic Defined Drug
Medical History
ROS
Medical Image
Encounter Type
Keywords
Education
Letter
Orders
Health Schedule
Consent Form
Authorization Form
Check Out Note
Facility
Group/Enc. Type
Message Type
POS
Consent Tabs
Enable Tab
Form Setup
User/Enc. Type
Mappings
CPT Modifier
Clinic Setup
List
Active Seq Description Short Description Yes Sentence No Sentence Gender
10 Constitutional Symptoms [pronoun cap] admits Patient denies Both
20 Eyes [pronoun cap] admits [pronoun cap] denies Both
30 Ear, Nose, Mouth, Throat [pronoun cap] admits [pronoun cap] denies Both
40 Cardiovascular [pronoun cap] admits Patient denies Both
50 Respiratory [pronoun cap] admits [pronoun cap] denies Both
51 Breast Breast [pronoun cap] complains [pronoun cap] denies Both
60 Gastrointestinal [firstname] admits Patient denies Both
70 Female Genitourinary [pronoun cap] admits Patient denies Female
80 Male Genitourinary [pronoun cap] admits Patient denies Male
90 Musculoskeletal [firstname] admits Patient denies Both
100 Integumentary Patient admits Patient denies Both
110 Neurological [pronoun cap] admits [pronoun cap] denies Both
120 Psychiatric [pronoun cap] notes Patient denies Both
130 Endocrine [pronoun cap] admits [pronoun cap] denies Both
140 Hematologic/Lymphatic Patient admits Patient denies Both
150 Allergic/Immunologic Patient admits [pronoun cap] denies Both
Detail
Add
Delete
Active Seq Symptom Short Description Positive Response Negative Response Default
10 Night Sweats night sweats night sweats N/A
20 Fever and Chills fevers and chills fevers and chills N/A
30 Hot flashes hot flashes hot flashes N/A
40 Fatigue fatigue fatigue N/A
50 Unexpected weight loss unexpected weight loss unexpected weight loss N/A
60 Weight loss due to diet weight loss due to diet weight loss due to diet N/A
70 Weight gain due to diet weight gain due to diet weight gain due to diet N/A
80 Unexpected weight gain unexpected weight gain unexpected weight gain N/A
90 Headaches headaches headaches N/A
100 Loss of appetite loss of appetite loss of appetite N/A
110 Sleep Disturbance sleep disturbance Sleep Disturbance N/A
120 Abnormal Activity Level abnormal activity level abnormal activity level N/A
130 Pallor pallor pallor N/A
140 Other N/A

The List pane is organized with the following column headings:

List

- Sequence
- Description
- Short Description
- Yes Sentence
- No Sentence
- Gender (drop-down list box)

Details

- Sequence
- Symptom
- Short Description
- Positive Response
- Negative Response

The List pane is used to create the List of Systems that will be covered for each patient. This section cannot be added to but can be edited. If you require an additional list, please contact your support team.

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The Detail pane is used to populate the symptoms associated with the questions setup in the List pane. The positive and negative responses are tied to the Yes and No answers. The Default column is a drop-down list that allows you to set the default values for the ROS Tab in the Encounter window.
To configure an ROS Detail, follow the steps outlined below:

a. Select *Settings->Clinic Setup->ROS*
b. Click on the *Details* pane to activate this area.
c. Click the **Add** icon on the toolbar or right-mouse click and select **Add** form the drop-down menu. A new row appears with a pre-filled sequence number.
d. Enter the Symptom Description and Short Description (used in PDA devices).
e. Enter the Positive and Negative response. These responses are tied to the Yes and No sentences you begun in the List pane.
f. Set the Default value for the symptom by using the drop-down list box.
g. Repeat steps c - f to add more records to the details pane. All records in the details pane will be tied to the Main category Highlighted in the List pane. See the example below for more on configuring the ROS Tab.

- Creating a new Details record and entering the description information (Short Description- optional for PDA devices).

Seq	Symptom	Short Description
10	Breast Pain	Breast Pain

- Entering Positive and Negative Responses and setting the default.

Positive Response	Negative Response	Default
breast pain	breast pain	No

The end result, based on how this ROS was configured will read as follows on the Progress note:

Yes Response to ROS **= "Patient admits to breast pain"**
No Response to ROS **= "Patient denies breast pain"**

Note: Due to the settings, only Females will get this ROS question and the default response will be "Yes."

51	Breast	Breast	[pronoun cap] complains	[pronoun cap] denies	Female

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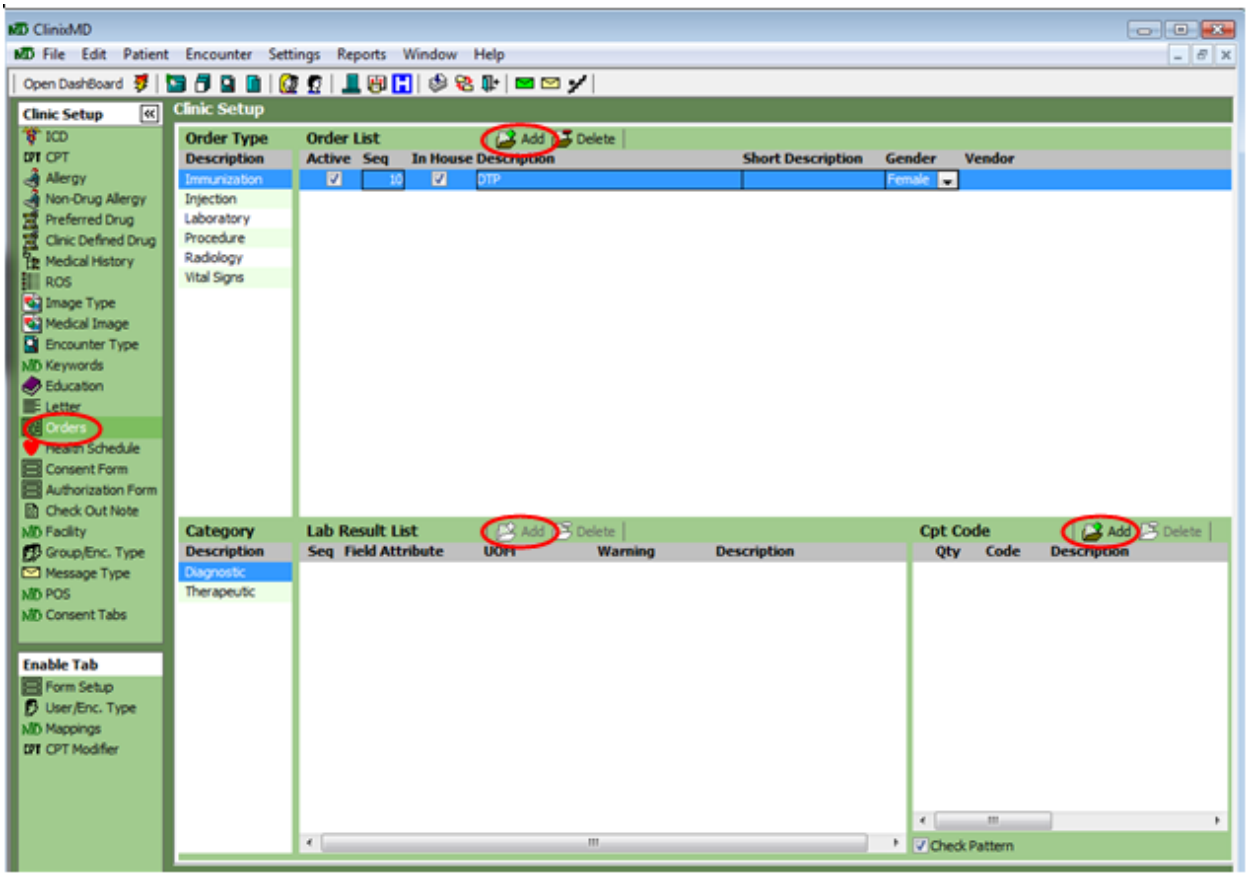
10. ORDERS

The ‘Orders’ tab is used to build the search windows that are used when adding orders in the correlating ‘Orders’ tab in patient encounters.



This tab is divided into five panes:

- **Order Type** – Lists the Order Types and include Laboratory, Injection, Procedure, Radiology, Immunization and Vital Signs.
- **Order Category** – For each order type, there can be two order categories, Diagnostic and Therapeutic.
- **Order List** – The Order List contains the items that will appear in the search window for each order type. This pane is organized with the following headings: Sequence number, In House checkbox, Description, Short Description and Gender.
- **Lab Results** – This section is used for Laboratory and Vital Signs order types only. Each lab or vital sign can have an associated lab result. This section contains the following: A field Attribute, A warning column for setting minimum and maximum ranges and a description.
- **CPT Code List** – This pane allows you to associate a CPT code with a particular order. This pane contains the code and a description for the code.

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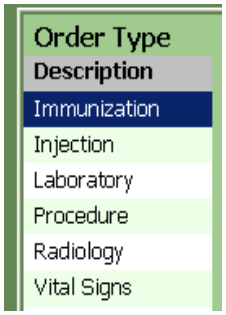
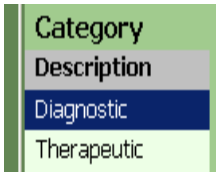
To add an Order, follow the steps outlined below:

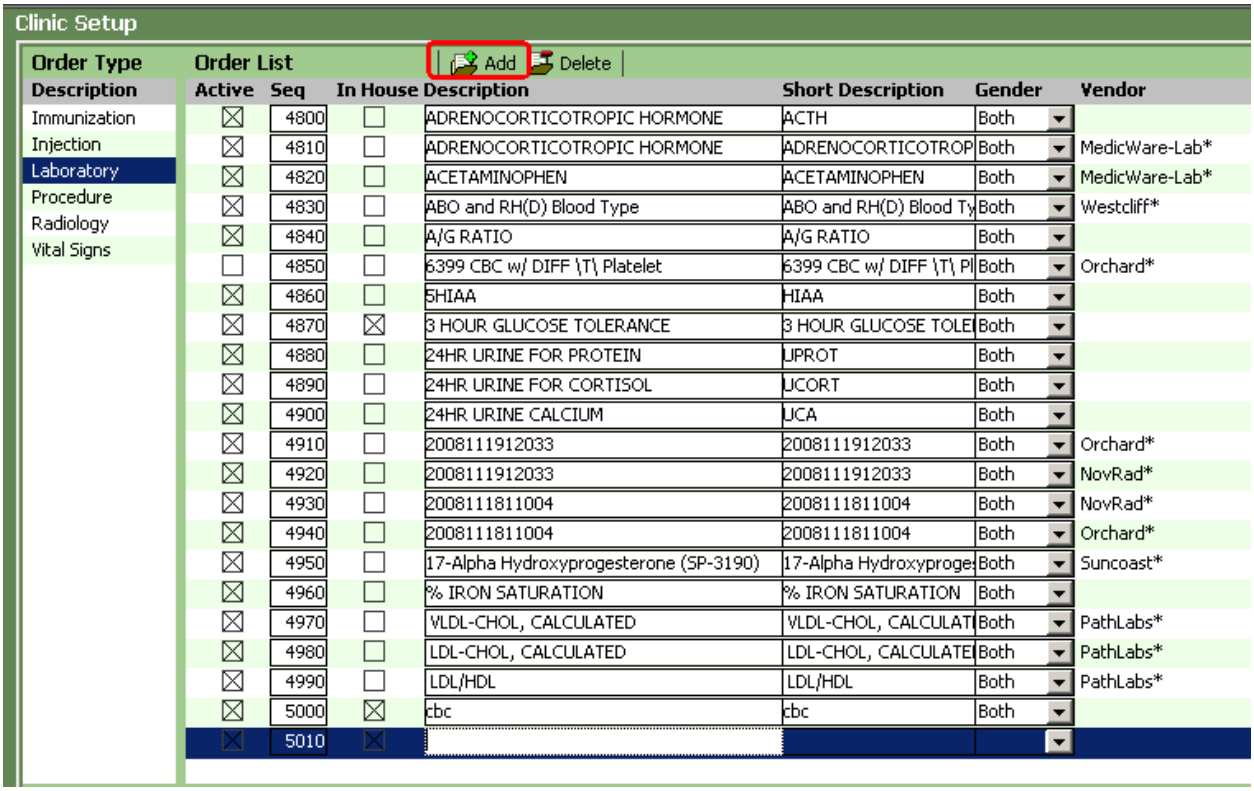
a. Select *Settings->Clinic Setup->Orders.*
b. Choose the appropriate type from the Order Type list and highlight it by clicking the *Order Type*.



c. Select the appropriate *Order Category* and highlight *Diagnostic* or *Therapeutic* by clicking the name in the list.



d. Click the **Add** button located to the right of **Order List**.
e. Uncheck the **In-House** checkbox if this order occurs outside the clinic.
f. Type in the **Description** and **Short Description** (used for PDA devices) for the order.
g. Select the **Gender** that will be attached to this order by using the drop-down list.


Clinic Setup
Order Type
Description
Immunization
Injection
Laboratory
Procedure
Radiology
Vital Signs
Order List
Add
Delete
Active Seq In House Description Short Description Gender Vendor
4800 ADRENOCORTICOTROPIC HORMONE ACTH Both
4810 ADRENOCORTICOTROPIC HORMONE ADRENOCORTICOTROP Both MedicWare-Lab*
4820 ACETAMINOPHEN ACETAMINOPHEN Both MedicWare-Lab*
4830 ABO and RH(D) Blood Type ABO and RH(D) Blood Ty Both Westcliff*
4840 A/G RATIO A/G RATIO Both
4850 6399 CBC w/ DIFF \T\ Platelet 6399 CBC w/ DIFF \T\ Pl Both Orchard*
4860 5HIAA HIAA Both
4870 3 HOUR GLUCOSE TOLERANCE 3 HOUR GLUCOSE TOLE Both
4880 24HR URINE FOR PROTEIN UPROT Both
4890 24HR URINE FOR CORTISOL UCORT Both
4900 24HR URINE CALCIUM UCA Both
4910 2008111912033 2008111912033 Both Orchard*
4920 2008111912033 2008111912033 Both NovRad*
4930 2008111811004 2008111811004 Both NovRad*
4940 2008111811004 2008111811004 Both Orchard*
4950 17-Alpha Hydroxyprogesterone (SP-3190) 17-Alpha Hydroxyproge Both Suncoast*
4960 % IRON SATURATION % IRON SATURATION Both
4970 VLDL-CHOL, CALCULATED VLDL-CHOL, CALCULAT Both PathLabs*
4980 LDL-CHOL, CALCULATED LDL-CHOL, CALCULATE Both PathLabs*
4990 LDL/HDL LDL/HDL Both PathLabs*
5000 cbc cbc Both
5010

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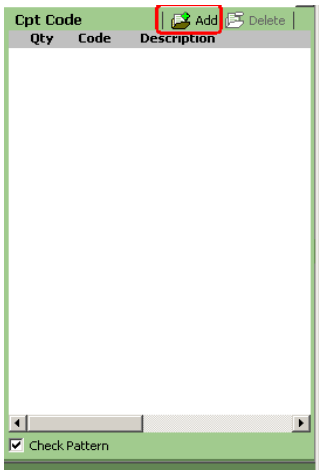
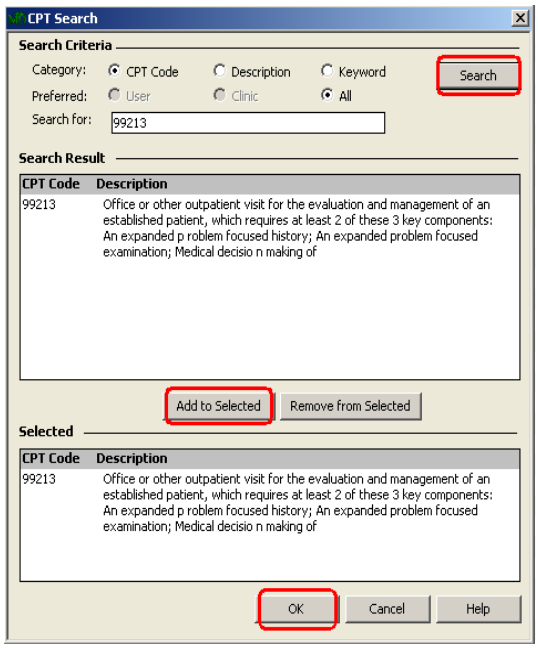
h. For orders marked as "**In-House:"** CPT codes can be added to an order and will automatically populate in the "Diagnosis" tab in an encounter when the order is marked as completed.



- Click the **Add** button located to the right of **CPT Code**.
- In the **CPT Search** pop-up window, choose to search for a CPT Code, Description or Keyword by clicking the *radio button* next to the labels. Enter partial or complete information in the free-text *Search For* field.
- Select the *Preferred* search list: User, Clinic or the "ALL" list (if the user/clinic does not have a code list, the system will default to the "ALL" list).
- Click the **Search** button to display a list in the *Search Result* pane.


CPT Search
Search Criteria
Category:
CPT Code
Description
Keyword
Search
Preferred:
User
Clinic
All
Search for:
99213
Search Result
CPT Code
Description
99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded p roblem focused history; An expanded problem focused examination; Medical decisio n making of
Add to Selected
Remove from Selected
Selected
CPT Code
Description
99213
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded p roblem focused history; An expanded problem focused examination; Medical decisio n making of
OK
Cancel
Help

- Highlight the desired *CPT Code* from the *Search Results* pane and click the **Add to Selected** button.
- If you wish to choose more than one CPT code at a time, select multiple codes from the *Search Results* Pane and before clicking the **Add to Selected** button.
- The selected code(s) will appear in the *Selected* pane located at the bottom of the search window.
- Click the **OK** button to add the codes to the order setup screen.

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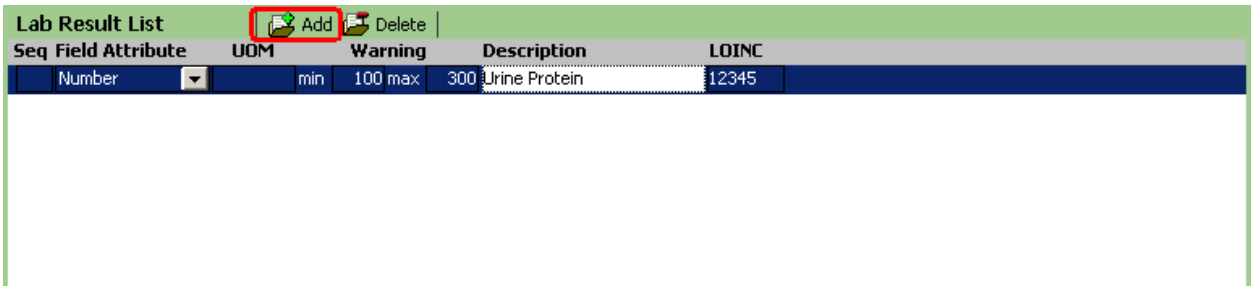
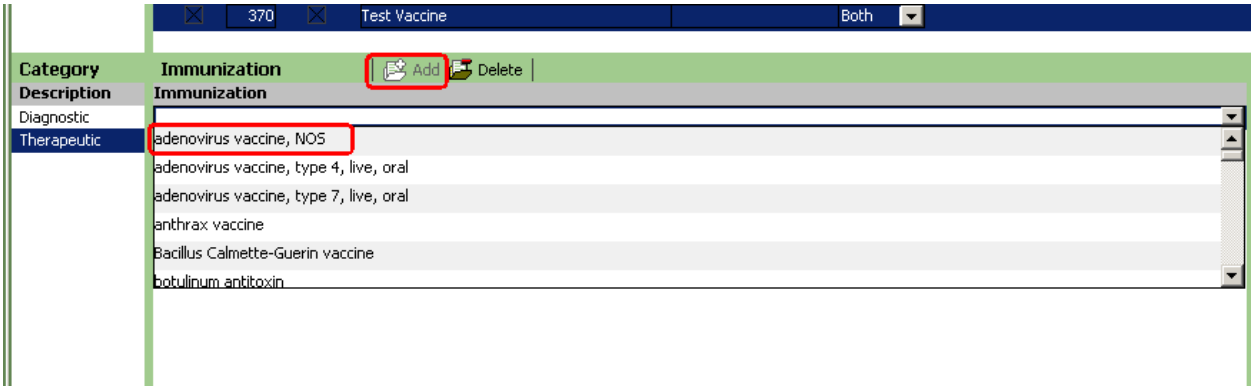
i. For **Laboratory** and **Vital Sign** orders, you can enter result parameters.
   - Select the desired lab from the **Order List** pane
   - Click the **Add** button located to the right of **Lab Result List** in the lower pane.
   - Select the expected data format in the **Field Attribute** drop-down list (i.e. text results, numerical results, etc.).
   - Enter the **UOM** (unit of measurement); if setting up for Vital Signs orders, the UOM will be displayed in the 'Vitals' tab in encounters and also in the progress note.
   - Enter the minimum and maximum result range; anything outside of this parameter will be displayed on screen in red.
   - The **Description** field is what is displayed on screen once the order is selected from the "Search" window.
   - LOINC codes can be added for lab, radiology and vital sign orders. This is a free-text field as there is not a look-up function for these codes in ClinixMD. A complete listing of LOINC codes can be found at www.loinc.org.



j. For **Immunization** orders, immunization codes (provided by the CDC) can be added (these are needed for the "Immunization Export" report).
   - Select the desired immunization from the **Order List** pane.
   - Click the **Add** button located to the right of **Immunization** in the lower pane.
   - Select the appropriate code from the drop down list; it will then be added to the immunization order.



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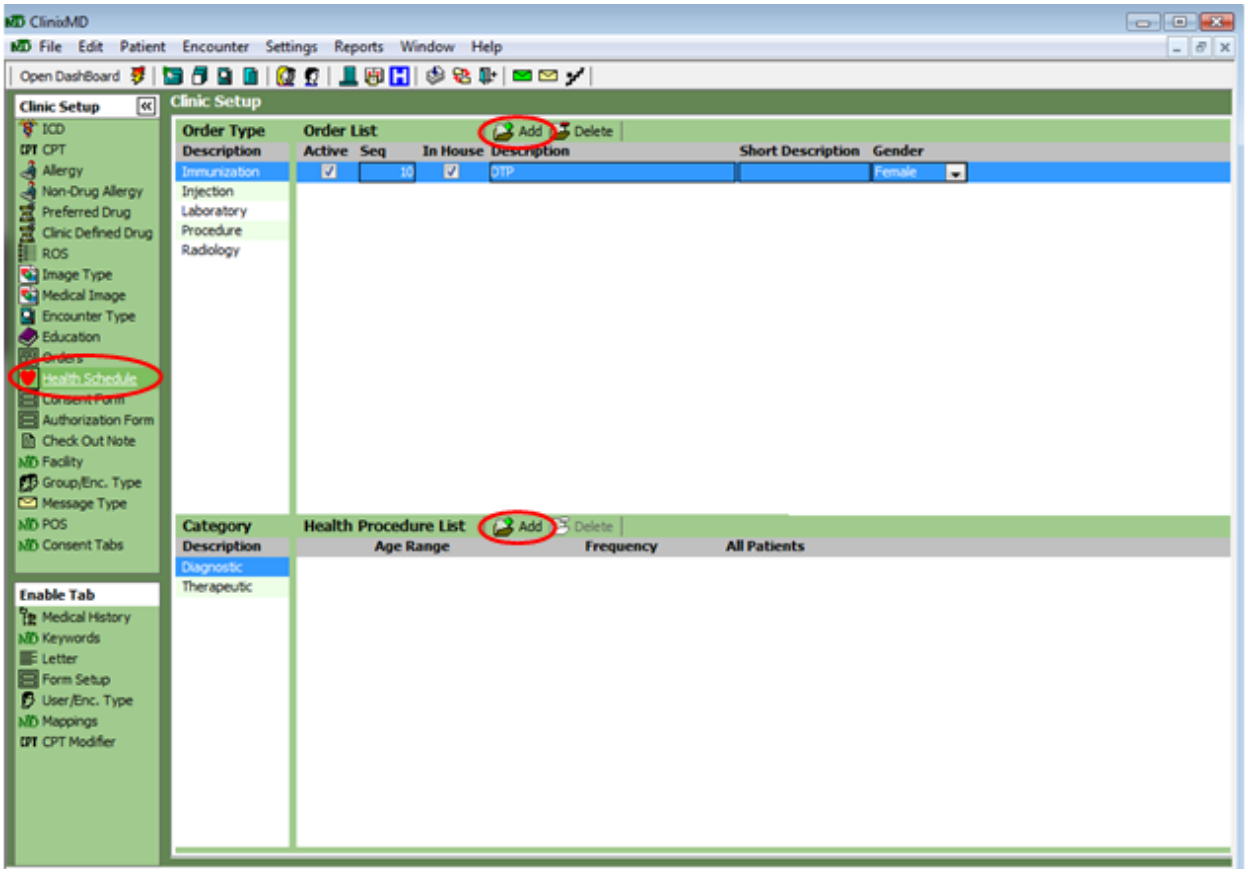
11. HEALTH SCHEDULE

The 'Health Schedule' tab is used to configure the items that will appear in the Health Schedule section of the Patient Information window and also in the "Health Schedule" tab in patient encounters. Some items can be configured to come up automatically as scheduled procedures for all patients. Others can be tailored to appear based on certain criteria. In addition to setting up scheduled procedures, this tab also allows the administrator to include items in the search window that can be added as additional health maintenance procedures.



This tab is divided into four panes:

Order Type – This section displays the order types that can be used to organize your procedures.

Order List – This pane contains the items that make up each category. Each order type can contain several items in the order list.

Order Category – Two categories are provided for each order type, Diagnostic or Therapeutic. When performing a search you can use the category Selections to filter your search.

Health Procedure List – This pane allows you to enter the parameters for each procedure. You can adjust the age range, frequency and the choice to include the procedure as a scheduled item.

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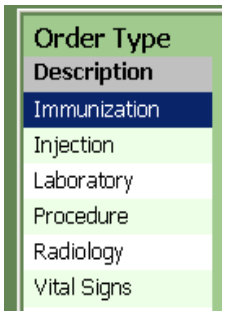
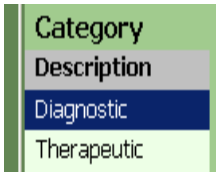
To create a Health Schedule item, follow the steps outlined below:

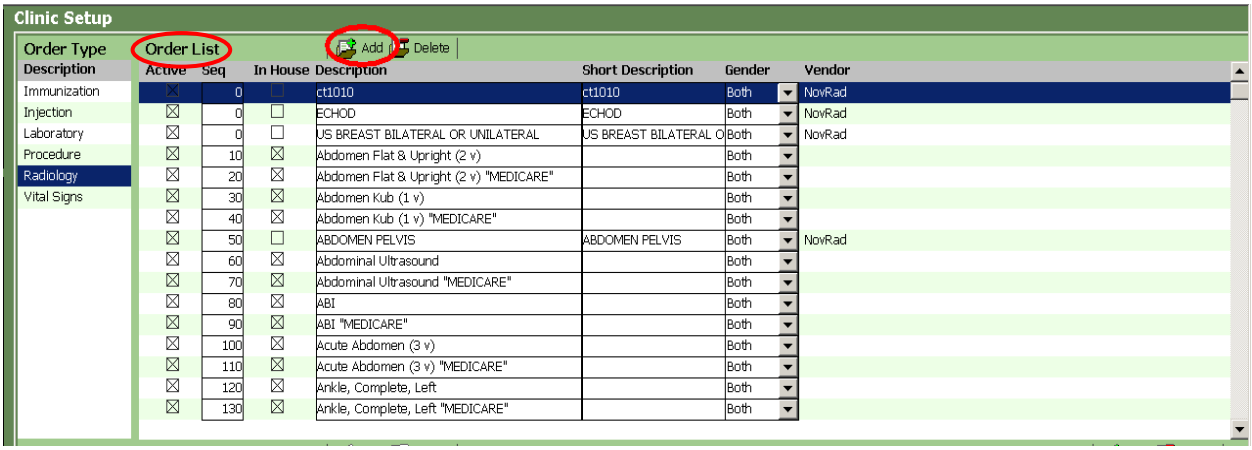
a. Select *Settings->Clinic Setup->Health Maintenance.*
b. Click the *Order Type* from the list provided.



c. Click the appropriate *Order Category* for the procedure (Diagnostic or Therapeutic).



d. Click the *Order List* pane to activate this section.
e. Click the **Add** icon from the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row appears in the Order List pane.
f. If the procedure is performed In-House, leave the checkbox marked. Deselect this setting if the procedure occurs outside your facility
g. Enter a Description and Short Description (used for PDA devices) in the appropriate fields.
h. Select a setting under the Gender column by using the drop-down list box. (See figure below)



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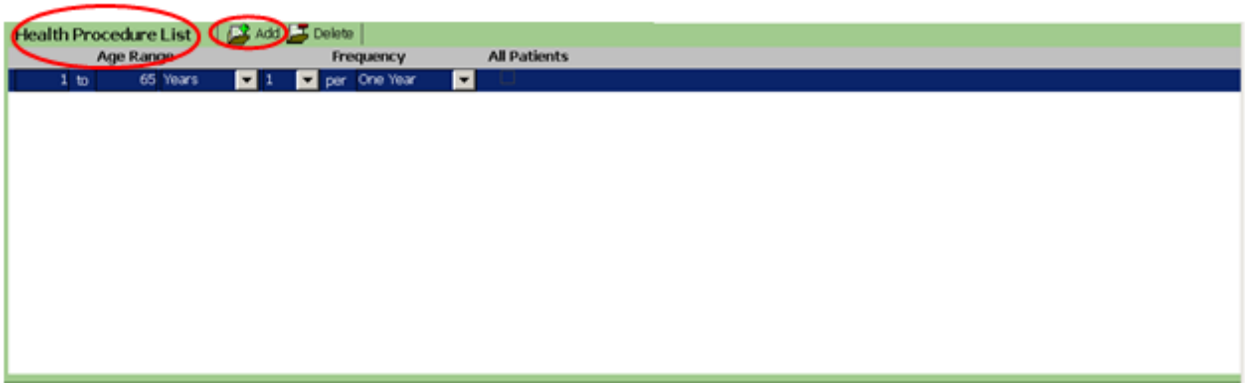
i. Click the *Health Procedure List* pane to activate this section.
j. Click the **Add** icon from the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row appears in the Health Procedure List pane.
k. Adjust the information for the Age Range and Frequency as necessary.
l. Check the *All Patients* box to automatically make this procedure a scheduled item. See figure below.



Note: Leaving the *All Patients* checkbox blank will make the item available in the search window to attach to a patient.

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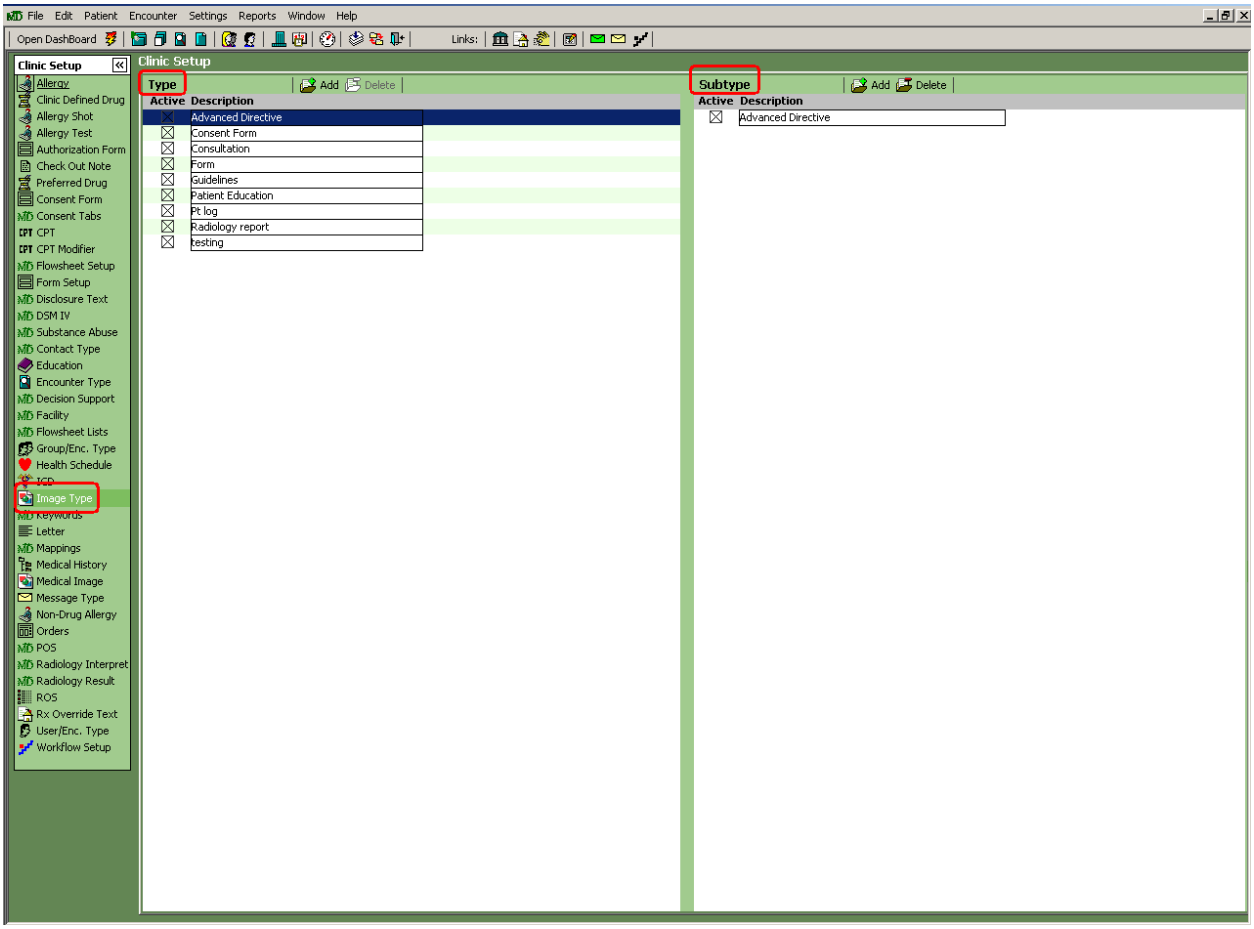
12. IMAGE TYPE

The 'Image Type' tab serves as a repository for the images that are used in the ClinixMD application and is comprised of two panes: Type and Subtype. Acceptable image file types include: .jpeg, .gif, .tif, .pdf, and .bmp.

The **Type** pane contains a list of image types that come standard with the application and cannot be deleted. Those codes that cannot be deleted are displayed with a gray background. All other image types created by the administrator can be edited and are displayed with a white background.

The **Subtype** pane contains sub-categories for each image type. A single image type can contain several subtypes. Once the types and subtypes are created, these categories are available to users when they scan or import images into the system.



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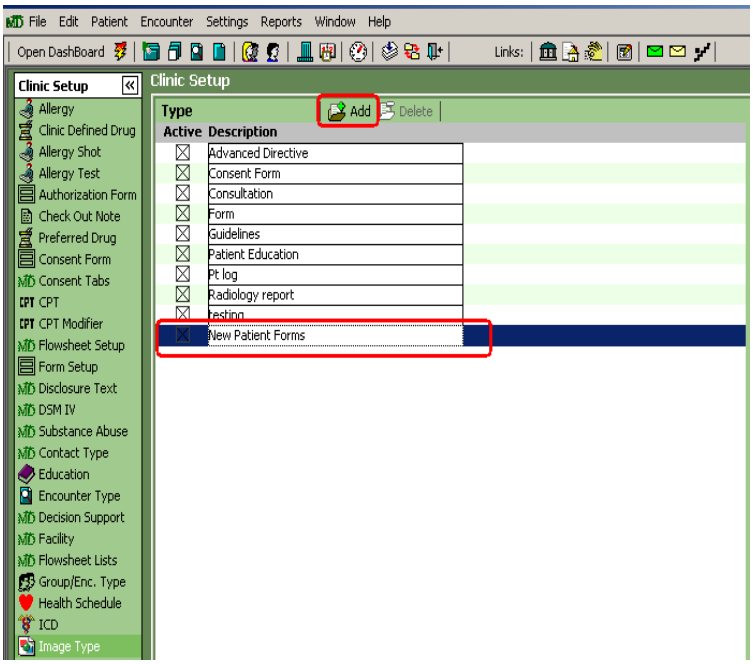
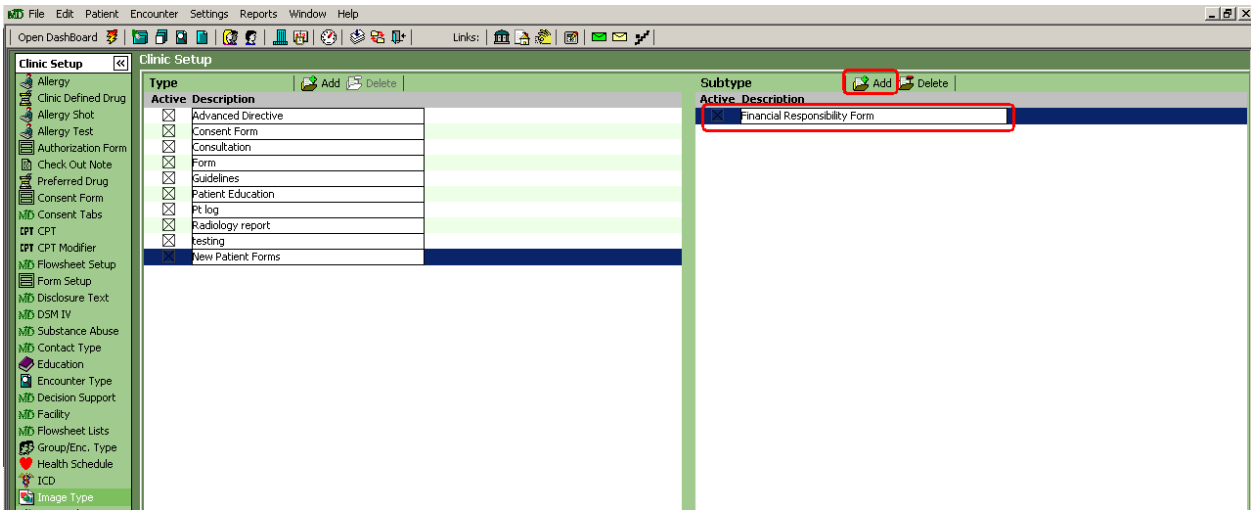
To add an Image Type, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Image Type*
b. Click the **Add** button located to the right of **Type.** A new row appears in the *Type* pane.
c. Enter the name of the image type in the **Description** field.



d. Click the **Add** button located to the right of **Subtype.** A new row appears in the *Subtype* pane.
e. Enter the name of the image subtype in the **Description** field.
f. Repeat steps e – g to add additional subtypes. See the figure below:



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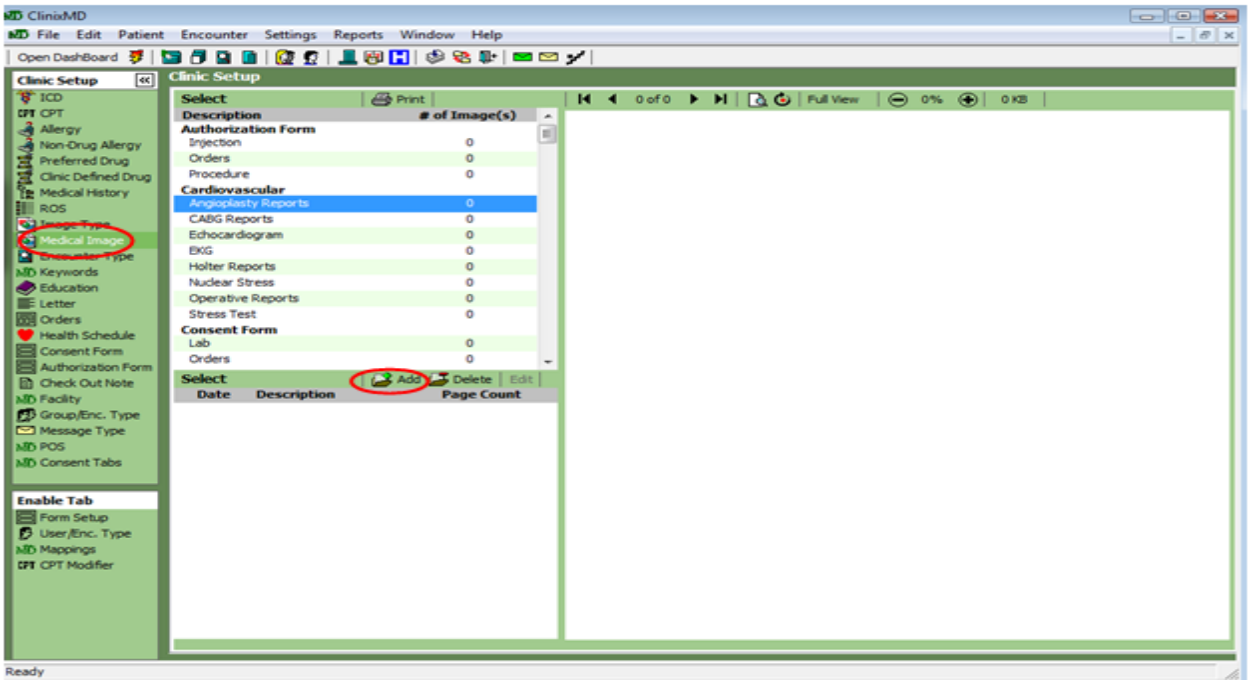
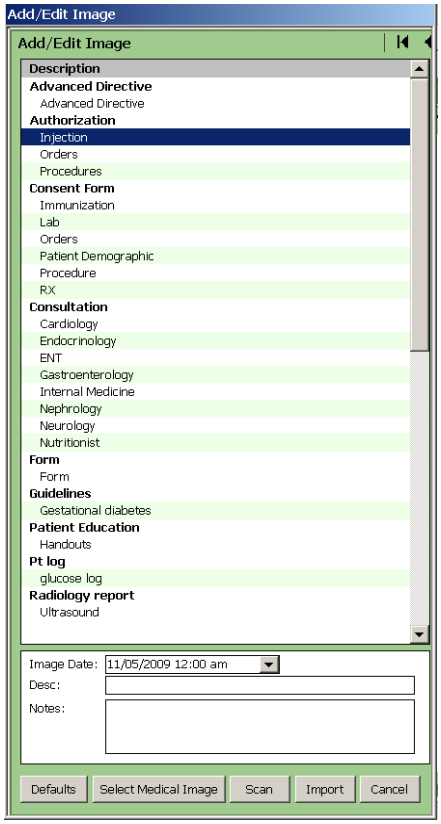
13. MEDICAL IMAGE

The 'Medical Image' tab is a centralized area for viewing and adding images that can then be imported into patient encounters in the "Images" tab.



To add a Medical Image, follow the steps outlined below:

a. Click the **Add** button located to the right of **Select** in the lower pane. The "Add/Edit Image" pop-up window is displayed:



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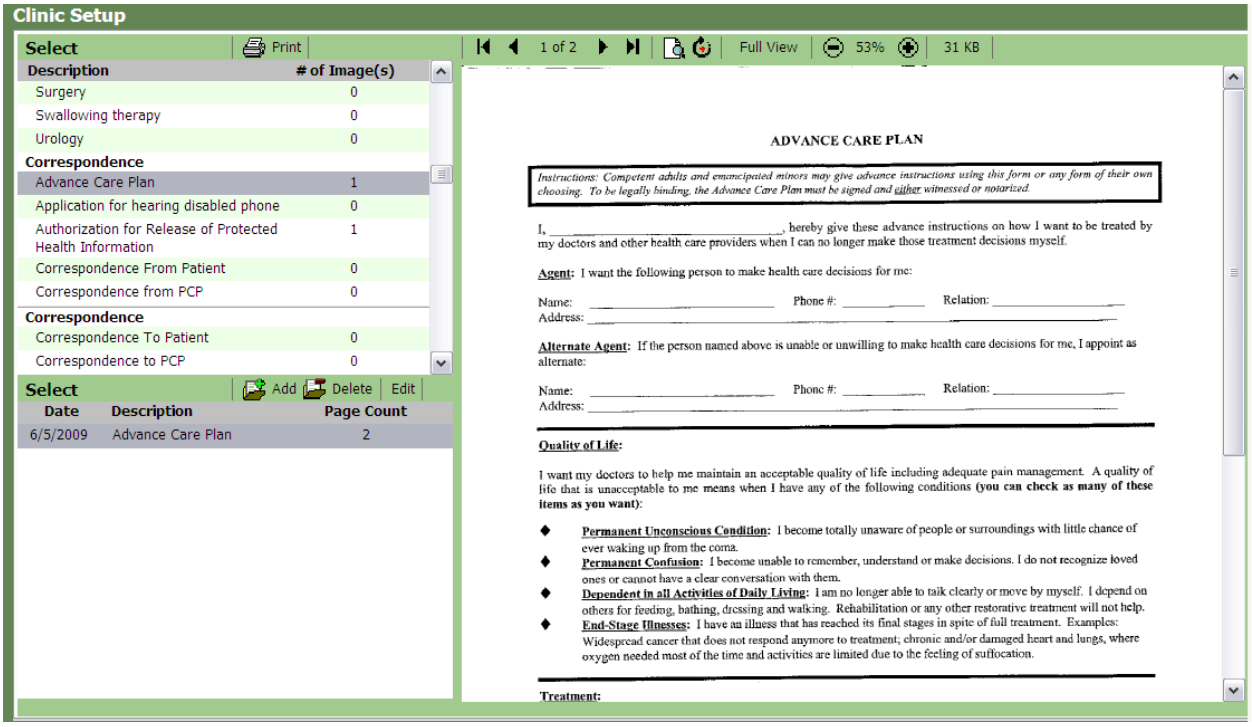
b. Select the *Image Subtype* for the form you are scanning.
c. Enter a Description for the form in the **Desc** free-text field. Additional information can be added in the free-text **Notes** field.
d. Click the **Defaults** button to set resolution (i.e. picture, text or sketch).
e. Click the **Scan** button to scan-in a new image/document; click the **Import** button to import a file from your computer.
f. A view of the image will be displayed on screen; click the **Save** button if the document/image scanned/imported correctly.


Clinic Setup
Select
Print
Description
# of Image(s)
Surgery 0
Swallowing therapy 0
Urology 0
Correspondence
Advance Care Plan 1
Application for hearing disabled phone 0
Authorization for Release of Protected Health Information 1
Correspondence From Patient 0
Correspondence from PCP 0
Correspondence
Correspondence To Patient 0
Correspondence to PCP 0
Select
Add
Delete
Edit
Date
Description
Page Count
6/5/2009 Advance Care Plan 2
1 of 2
Full View
53%
31 KB
ADVANCE CARE PLAN
Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.
I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.
Agent: I want the following person to make health care decisions for me:
Name: _____ Phone #: _____ Relation: _____
Address: _____
Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:
Name: _____ Phone #: _____ Relation: _____
Address: _____
Quality of Life:
I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):
Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.
Treatment:

g. After the scanning or importing process is completed, the form will be added to the list of available Medical Images forms for the clinic.
h. Repeat steps b – f to add additional forms.

To delete a Medical Image, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Medical Image.*
b. Highlight the *Medical Image* you want to delete from the list in the Medical Image tab.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK*.

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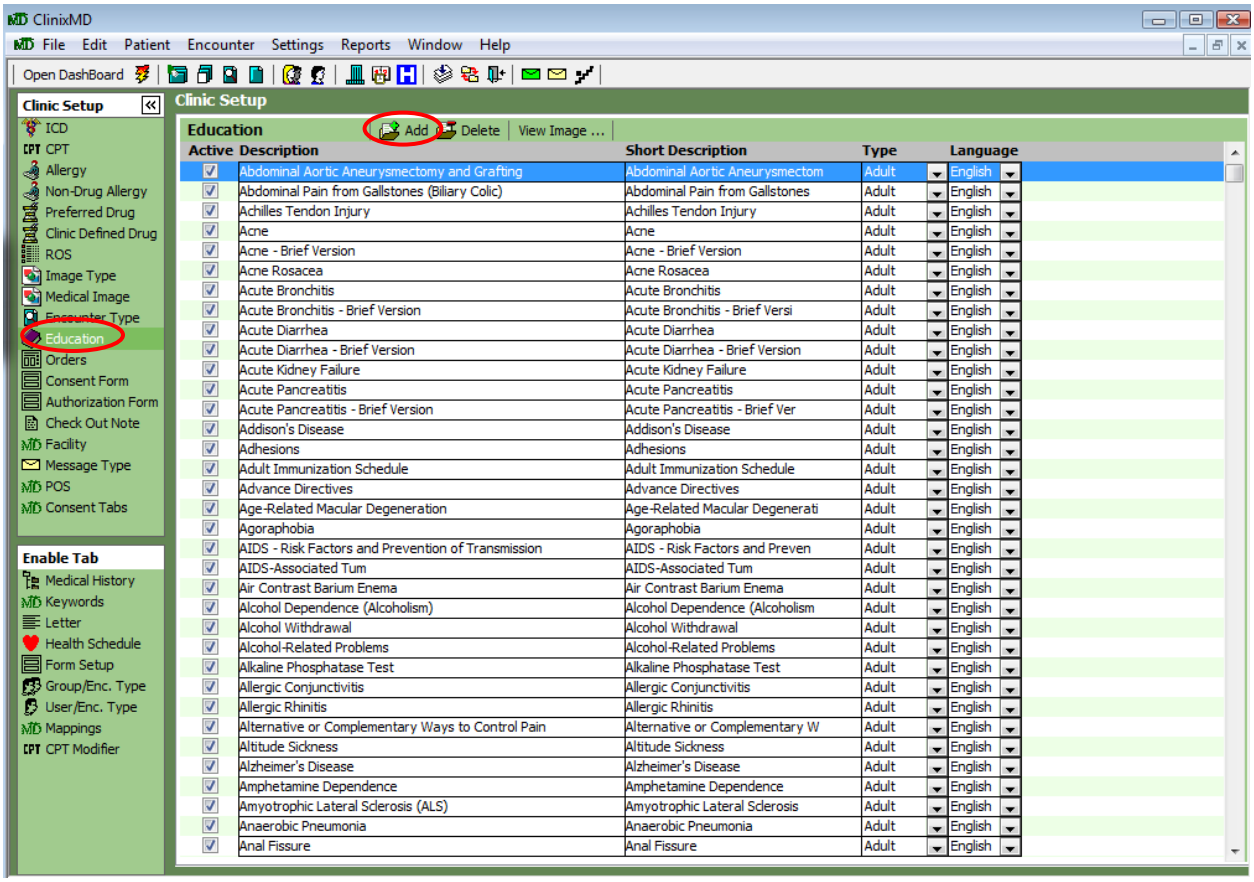
14. EDUCATION

The 'Education' Tab is used to store all periodical information concerning patient education. Each record contains a description and a short description to identify the record. Each item also has an image of the pertinent documentation attached to the record. The ClinixMD application comes standard with numerous educational handouts but the administrator can add additional items as needed. Once the list has been created, it is available to the clinic personnel for distribution to patients. The documents can be printed from this section, from the 'Education' tab in the Patient Information window or from the 'Education' tab in an encounter.



To add an Education record, follow the steps outlined below:

a. Add the item to the 'Medical Image' tab
b. Next, select *Settings->Clinic Setup->Education*
c. Click the "Add" button, located to the right of **Education**; the Add/Edit window is displayed:

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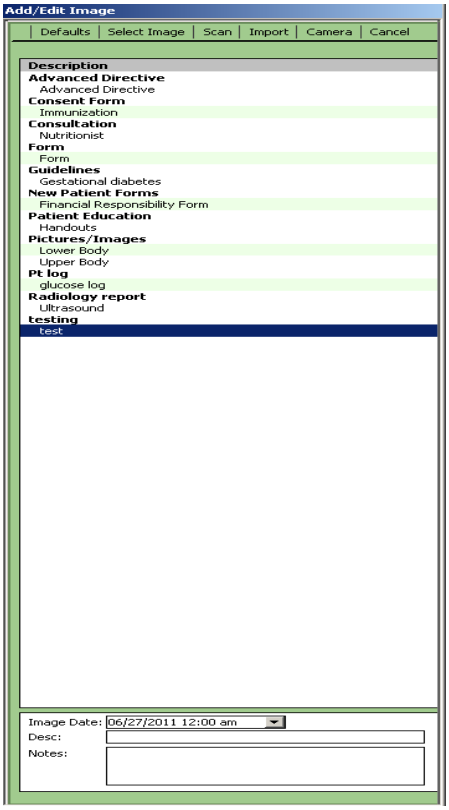
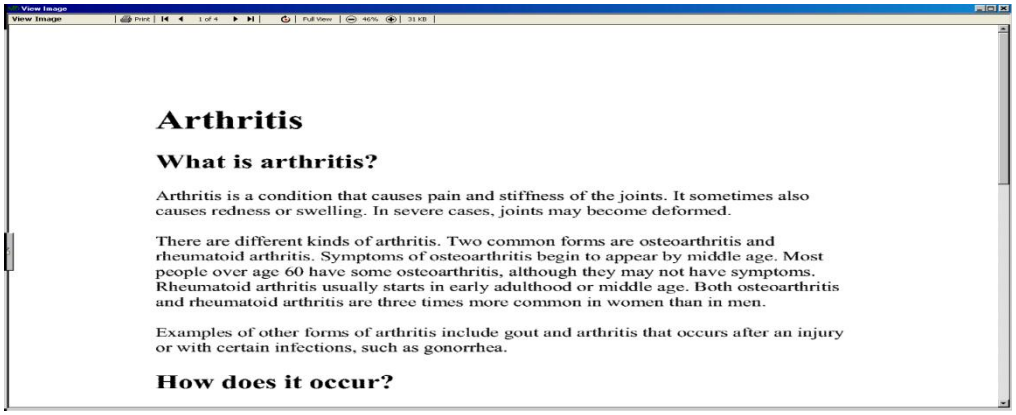


d. Enter a description and notes and select *Scan* or *Import.*
e. Click the "Save" button in the Edit/Add Image window.


View Image
Arthritis
What is arthritis?
Arthritis is a condition that causes pain and stiffness of the joints. It sometimes also causes redness or swelling. In severe cases, joints may become deformed.
There are different kinds of arthritis. Two common forms are osteoarthritis and rheumatoid arthritis. Symptoms of osteoarthritis begin to appear by middle age. Most people over age 60 have some osteoarthritis, although they may not have symptoms. Rheumatoid arthritis usually starts in early adulthood or middle age. Both osteoarthritis and rheumatoid arthritis are three times more common in women than in men.
Examples of other forms of arthritis include gout and arthritis that occurs after an injury or with certain infections, such as gonorrhea.
How does it occur?

f. Select *Type* and *Language.*
g. Repeat steps as needed for additional educational forms.

To delete an Education record, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Education.*
b. *Click* on the *Education* record you want to delete.
c. *Click* on the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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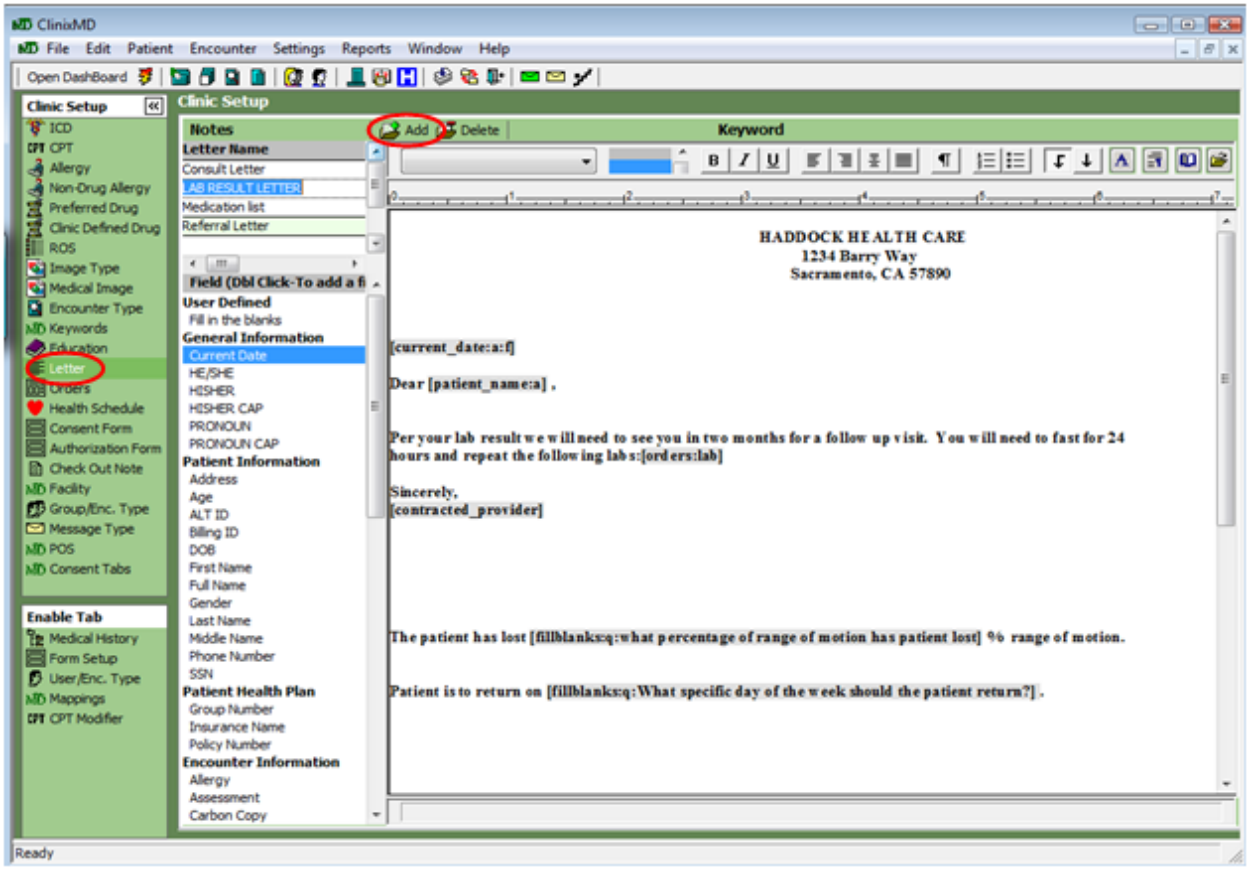
15. LETTERS

The 'Letters' tab is used to build letter templates, such as referral letters, medication lists, etc., that can be pulled into a patient's encounter and then printed/faxed as needed. Building a letter template is similar to the logic used in Microsoft Word. The Letters tab consists of three panes: letter name, fields, and the body of the template.



To create a Letter, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Letter*
b. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays in the Letter Name pane.
c. Enter the Letter Name in the text field provided.
d. To add your logo to the letter, Select *File Open* on the toolbar and browse your folders to attach your logo. The logo must be a .doc file extension.
e. Start building the Letter template by doubling clicking the fields to be included in the body of the letter.
f. Repeat these steps to capture all fields that you want captured in the document.
g. When the template is applied to encounter, the fields chosen will default with the information captured within the encounter and default in the letter template.

To delete a Letter, follow the steps outlined below:

e. Select *Settings->Clinic Setup->Keyword.*
f. From the Letters tab, highlight the letter you want to delete from the List pane.
g. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
h. Confirm your deletion by clicking *OK.*

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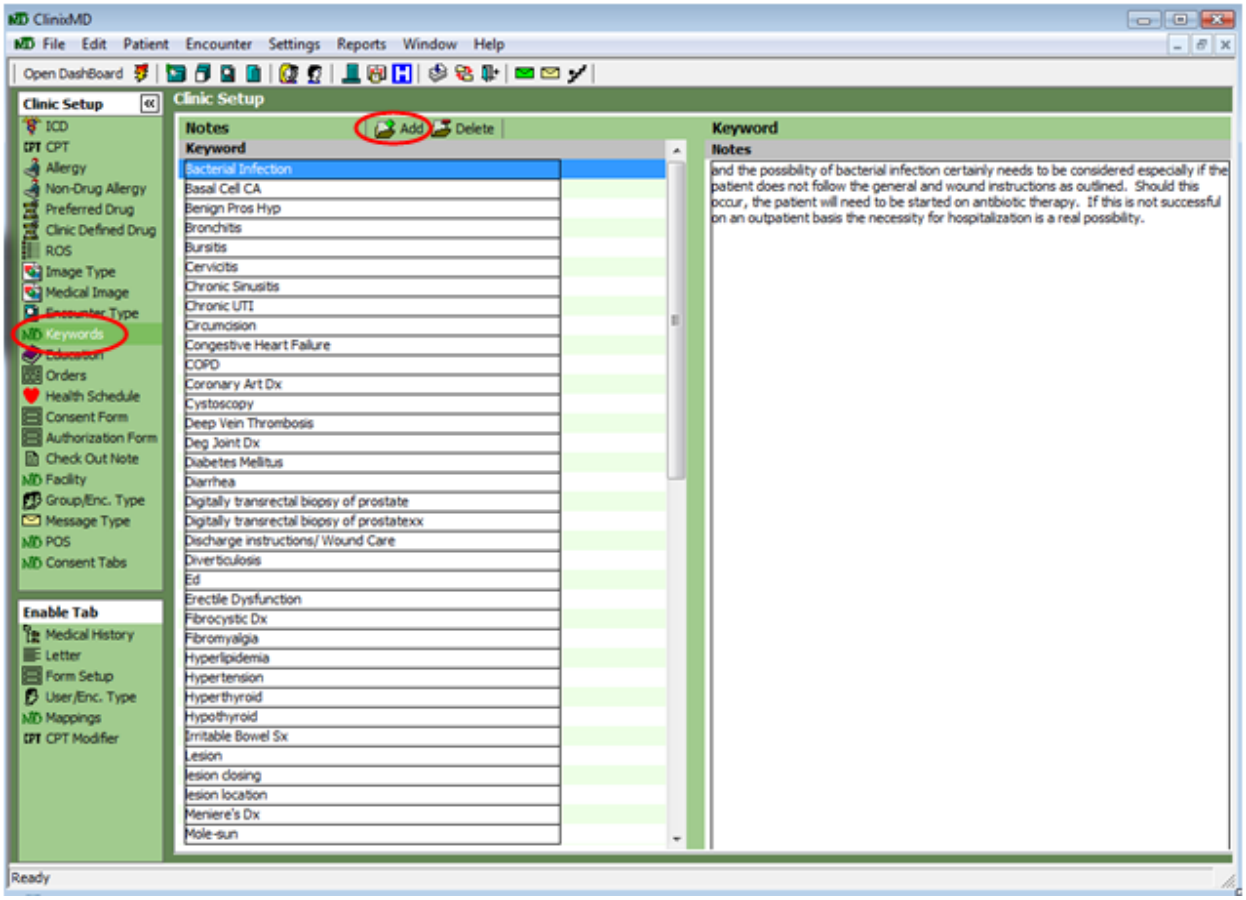
16. KEYWORDS

The 'Keyword' tab is used to shorten the amount of typing a user needs to do when adding notes. The administrator uses a Keyword to identify multiple lines of text concerning a particular medical subject. After creating this Keyword, a user can simply type this word (using brackets, Example: [keyword] in the notes for several areas in the application.



This tab is divided into two panes. The Keyword pane displays all the Keywords available to the users. The Notes pane displays the text associated with each Keyword. Once the Keyword is defined, it can be used in the Notes section of the following areas:

- CC/HPI
- Exam
- Plan
- Procedures
- ROS (in the Explanation text field)

The complete text associated with the Keyword will appear in the appropriate places of the Progress Note.

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To add a new Keyword, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Keyword*.
b. From the Keyword tab, click in the *Keyword Pane* to activate this section.
c. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays in the Keyword pane.
d. Enter the label for the Keyword in the text field provided.
e. Click in the *Notes* pane under the Keyword heading to type in the text you want to associate with the keyword.
f. Repeat steps b-e for additional keywords.

To remove a Keyword, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Keyword.*
b. From the Keyword tab, highlight the *Keyword* you want to delete from the List pane.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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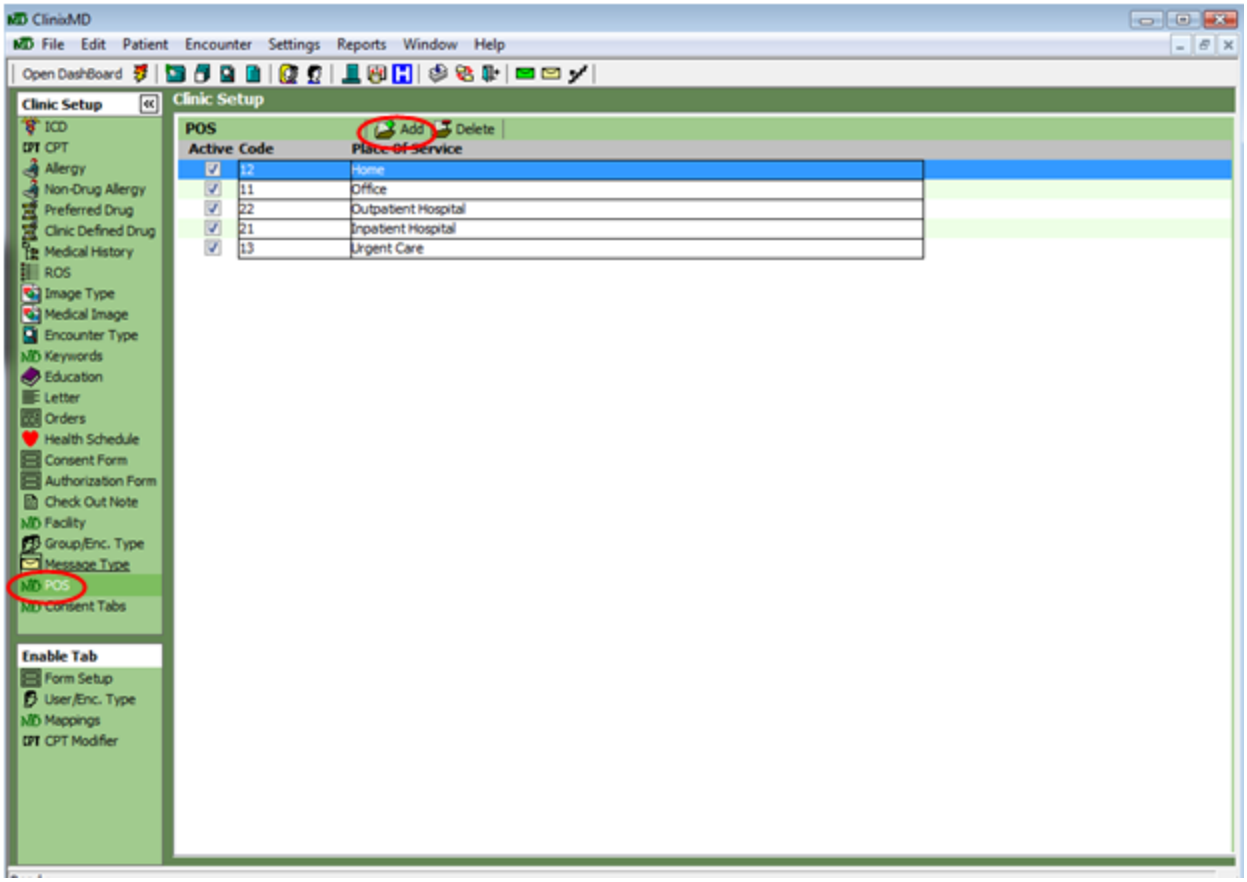
17. POS

The 'POS' (Place Of Service) tab is used to maintain the list of place of service locations/codes used for billing. This list is displayed as a drop-down list box in the 'Encounter' tab in patient encounters and is also attached to the specific CPT codes assigned in the 'Diagnosis' tab in patient encounters.



To add a POS, follow the steps outlined below:

a. Select *Settings->Clinic Setup->POS.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row appears in the POS tab.
c. Fill in the name of the new place of service, as well as the POS billing code.
d. Repeat the above steps as necessary.

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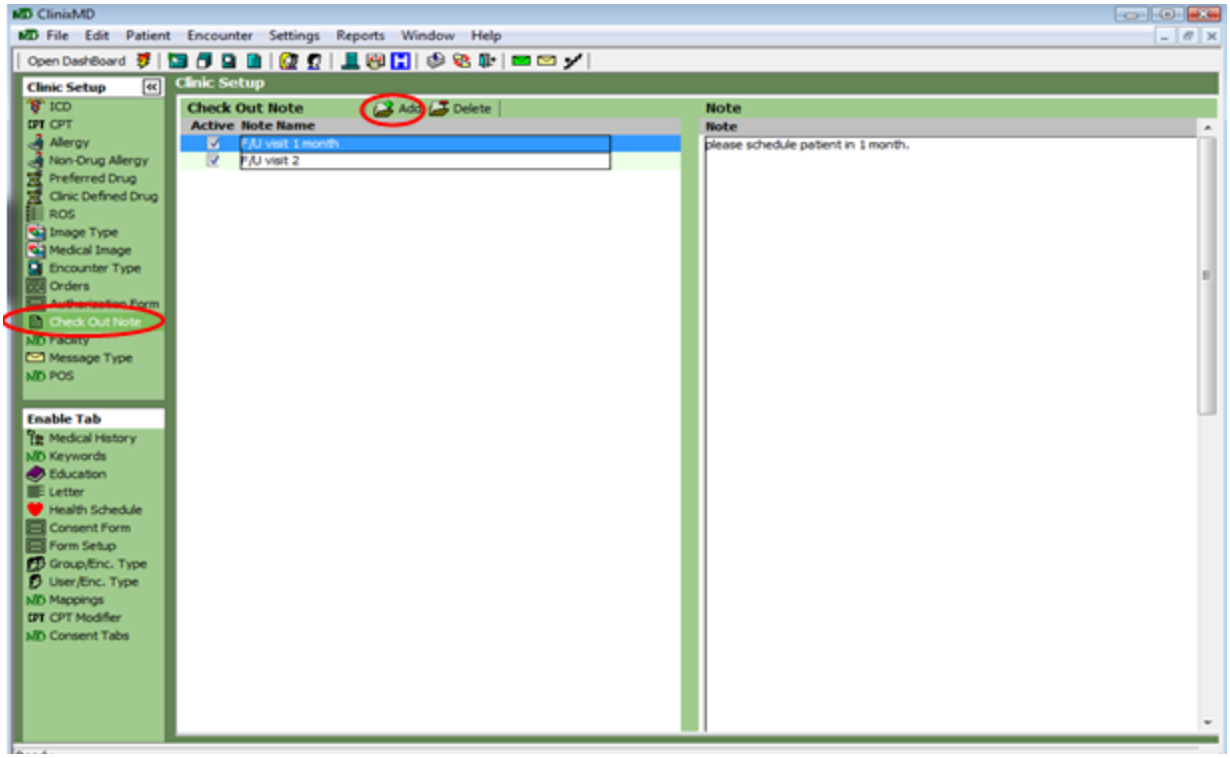
18. CHECK OUT NOTE

The 'Check Out Note' tab is used to create default check-out notes that can be included when the 'Check-Out' button is selected when an office visit is complete. The 'Check Out Note' tab is divided into two panes: The Check Out Note Name pane and Note pane.



To add a Check Out Note to the Clinic Setup, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Check Out Note.*
b. In the Note Name pane select the **Add** icon on the toolbar or right-mouse click and select **Add**. A new row displays.
c. Enter the description for the Note Name in the field provided.
d. In the Note pane, free text the note you want to associate the Note Name with.

To delete a Check Out Note, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Check Out Note.*
b. From the Check Out Note tab, highlight the Check Out Note you wish to delete from the Clinic List.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK.

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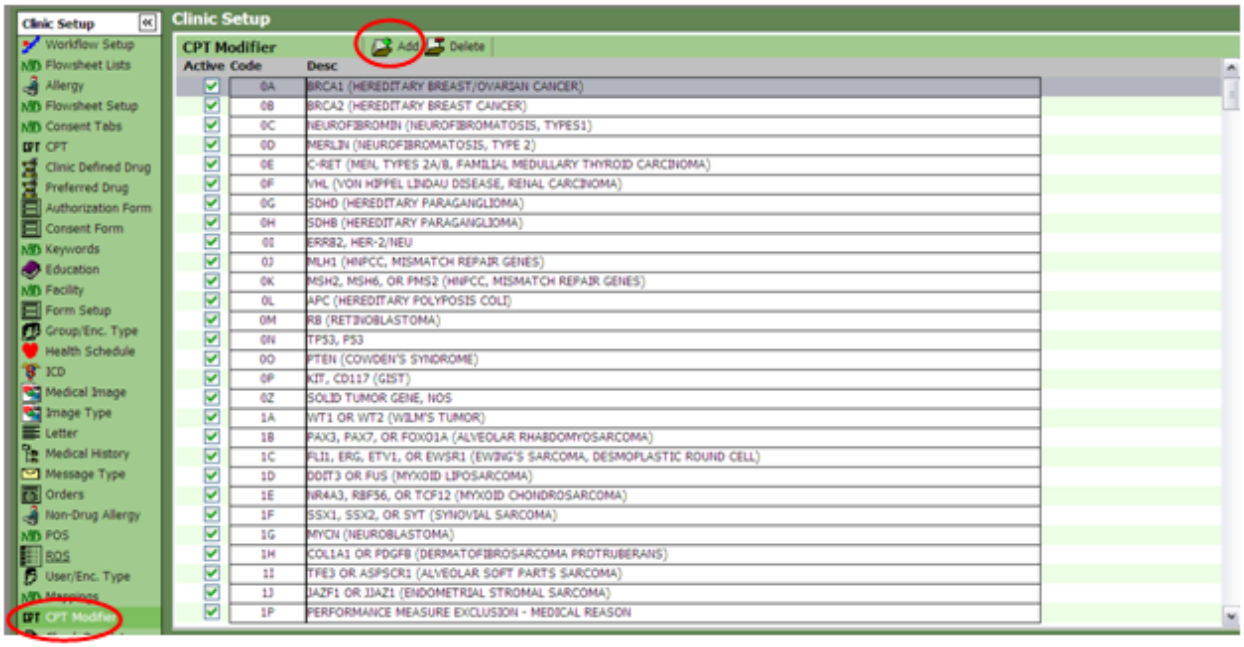
19. CPT MODIFIER

The 'CPT Modifier' tab is used to create a standardized list of common choices for the clinic. After the Administrator sets up this list, it then becomes available to the entire clinic. When a staff member uses the CPT Modifier search window in the 'Diagnosis' tab within patient encounters, the Clinic Preferred List displays only those items chosen by the Administrator.



To add a CPT Modifier, follow the steps outlined below:

a. Select *Settings->Clinic Setup->CPT Modifier.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add.** A new row displays.
c. Enter the CPT Modifier code and description.

To delete a CPT Modifier code, follow the steps outlined below:

a. Select *Settings->Clinic Setup->CPT Modifier.*
b. From the CPT Modifier tab, highlight the *CPT Modifier* you wish to delete from the Clinic List.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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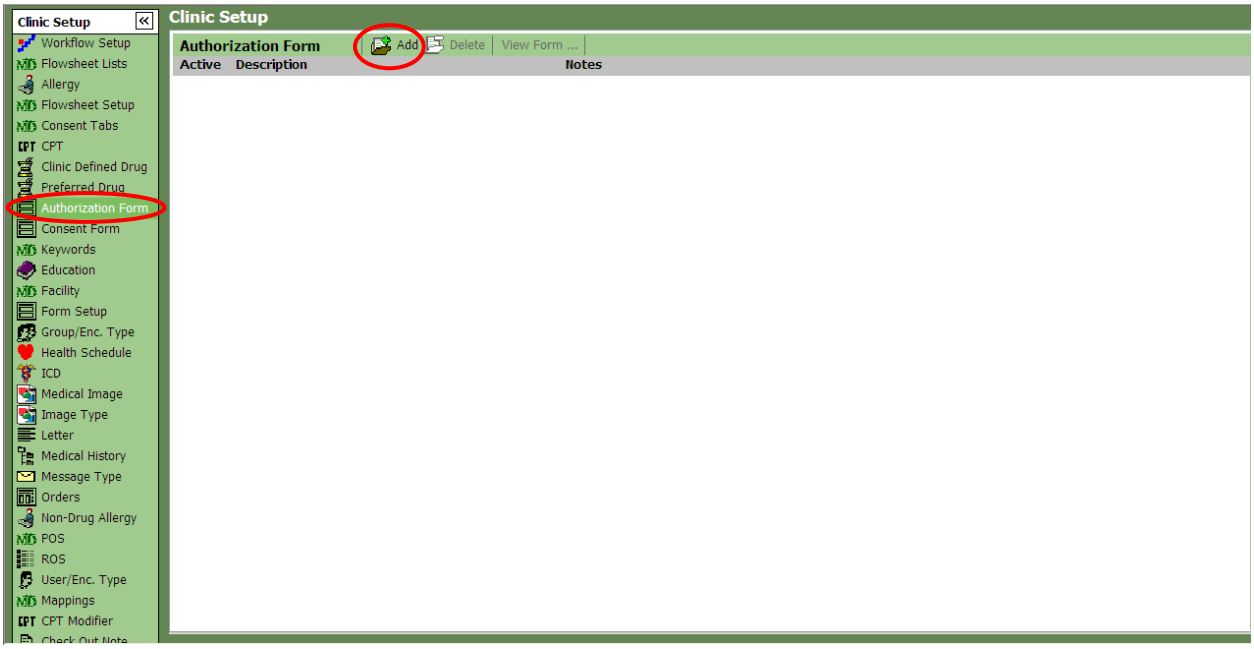
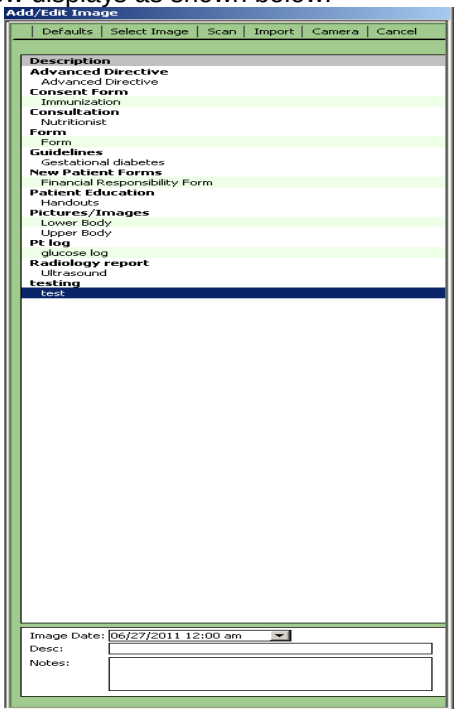
20. AUTHORIZATION FORM

The 'Authorization Form' Tab is used to create the authorization forms for the clinic. Attached to each form is the ability to scan or import a form for each Authorization. Once the Administrator sets up the Authorization form, clinic personnel can use these forms when dealing with Patients.



To add an Authorization Form, follow the steps outlined below:

a. Import the form into the '[Medical Image](#)' tab.
b. Select *Settings->Clinic Setup->Authorization Form.*
c. Click the **Add** icon on the toolbar or right-mouse click and select **Add**. A new row displays and the Add/Edit Image window displays as shown below:



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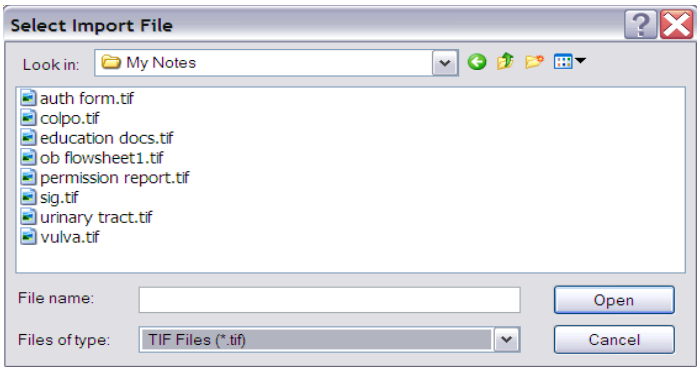
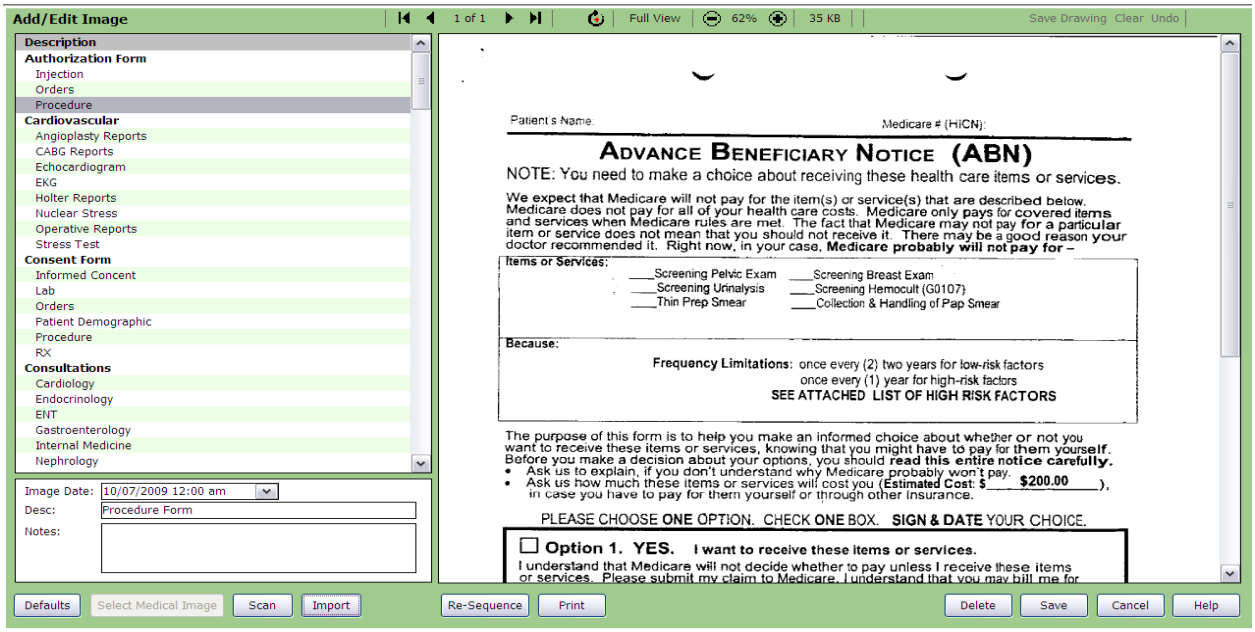
d. Select the *Image Subtype* for the form you are scanning
e. Enter a Description for the form in the Description pane. Add notes if needed in the field provided.
f. Click the *Scan* or *Import* button to import the form.



g. From the Add/Edit Image window, confirm your scan or import and Select **Save** as show below:


Add/Edit Image
1 of 1
Full View
62%
35 KB
Save Drawing
Clear
Undo
Description
Authorization Form
Injection
Orders
Procedure
Cardiovascular
Angioplasty Reports
CABG Reports
Echocardiogram
EKG
Holter Reports
Nuclear Stress
Operative Reports
Stress Test
Consent Form
Informed Concent
Lab
Orders
Patient Demographic
Procedure
RX
Consultations
Cardiology
Endocrinology
ENT
Gastroenterology
Internal Medicine
Nephrology
Image Date:
10/07/2009 12:00 am
Desc:
Procedure Form
Notes:
Patient's Name:
Medicare # (HICN):
ADVANCE BENEFICIARY NOTICE (ABN)
NOTE: You need to make a choice about receiving these health care items or services.
We expect that Medicare will not pay for the item(s) or service(s) that are described below.
Medicare does not pay for all of your health care costs. Medicare only pays for covered items
and services when Medicare rules are met. The fact that Medicare may not pay for a particular
item or service does not mean that you should not receive it. There may be a good reason your
doctor recommended it. Right now, in your case, Medicare probably will not pay for –
Items or Services:
___Screening Pelvic Exam
___Screening Breast Exam
___Screening Urinalysis
___Screening Hemocult (G0107)
___Thin Prep Smear
___Collection & Handling of Pap Smear
Because:
Frequency Limitations: once every (2) two years for low-risk factors
once every (1) year for high-risk factors
SEE ATTACHED LIST OF HIGH RISK FACTORS
The purpose of this form is to help you make an informed choice about whether or not you
want to receive these items or services, knowing that you might have to pay for them yourself.
Before you make a decision about your options, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare probably won't pay.
Ask us how much these items or services will cost you (Estimated Cost: $ $200.00),
in case you have to pay for them yourself or through other insurance.
PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.
Option 1. YES. I want to receive these items or services.
I understand that Medicare will not decide whether to pay unless I receive these items
or services. Please submit my claim to Medicare. I understand that you may bill me for
Defaults
Select Medical Image
Scan
Import
Re-Sequence
Print
Delete
Save
Cancel
Help

h. After the scanning or importing process is completed, the form will be added to the list of available Consent forms for the clinic.
i. Repeat steps b – f to add additional forms.

To delete an Authorization Form, follow the steps outlined below:

e. Select *Settings->Clinic Setup->Authorization Form.*
f. Highlight the *Form* you want to delete from the list in the Authorization Form tab.
g. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
h. Confirm your deletion by clicking *OK*.

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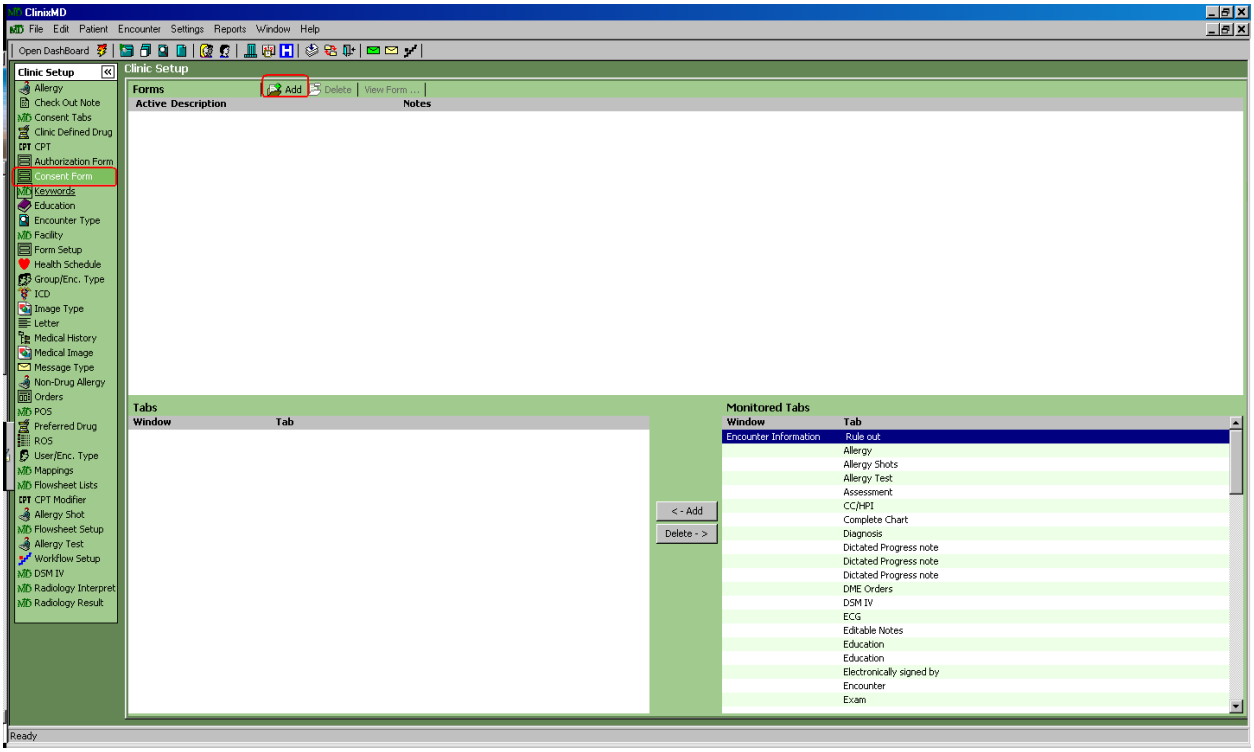
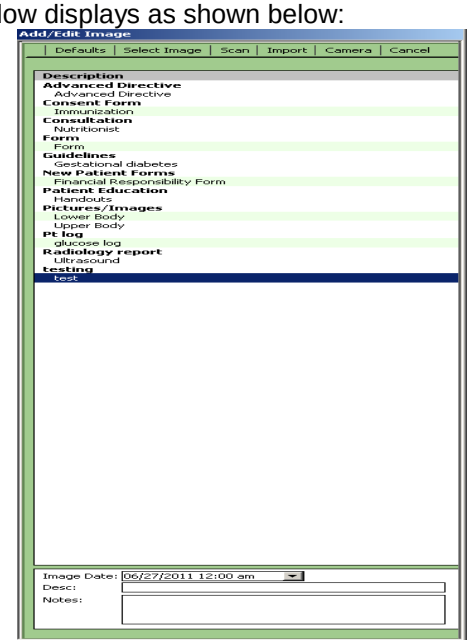
21. CONSENT FORM

The 'Consent Form' Tab is used to create the consent forms for the clinic. Attached to each form is the ability to scan or import a form for each Consent Form description. Once the Administrator sets up the Consent Form, clinic personnel can use these forms when treating patients.



To add a Consent Form, follow the steps outlined below:

a. Import the form into the '[Medical Image](#)' tab.
b. Select *Settings->Clinic Setup->Consent Form.*
c. Click the **Add** icon on the toolbar or right-mouse click and select **Add**. A new row displays and the Add/Edit Image window displays as shown below:



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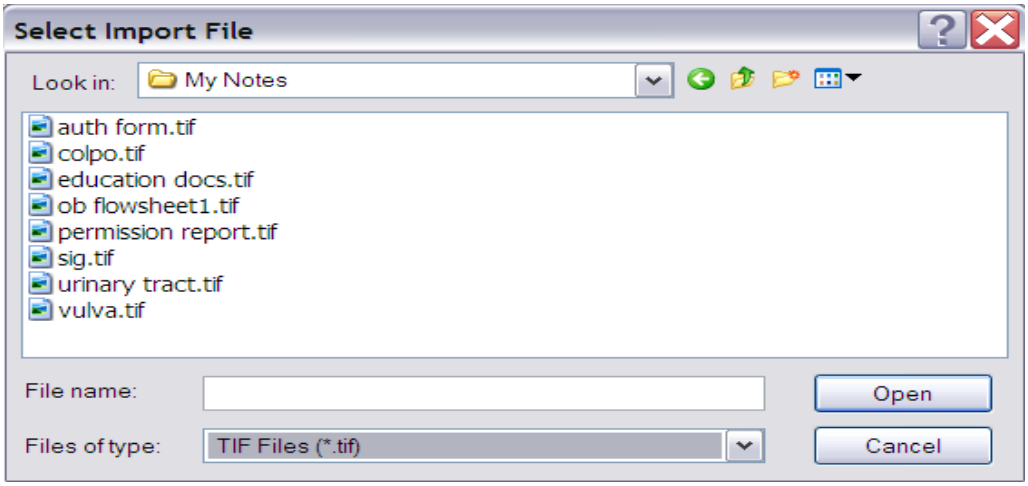
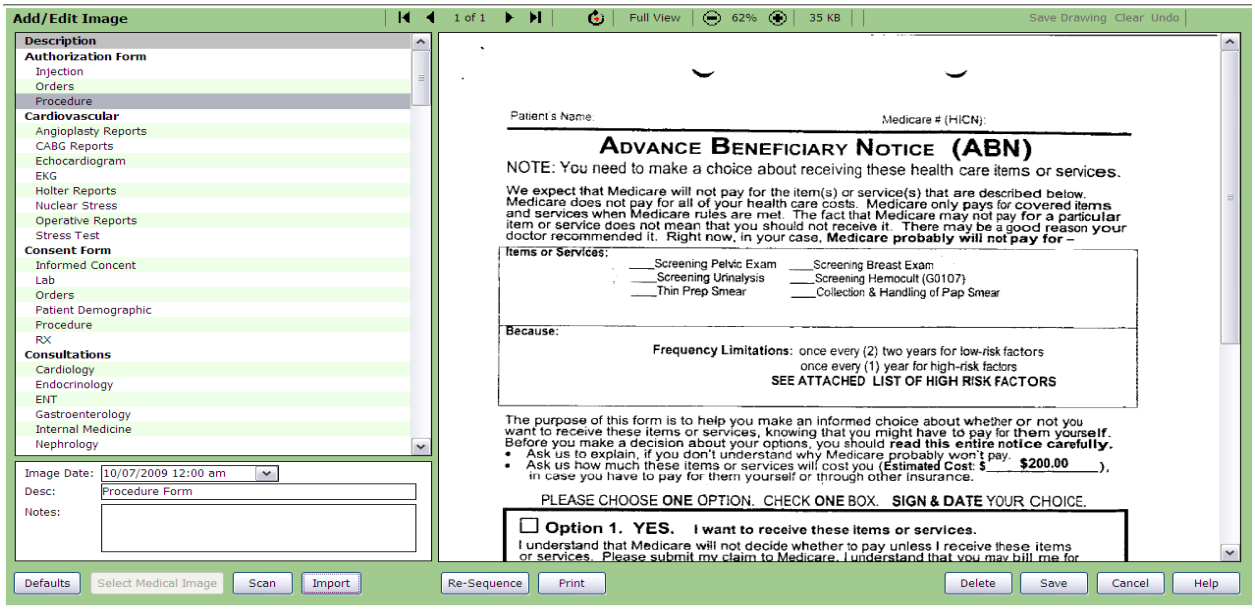
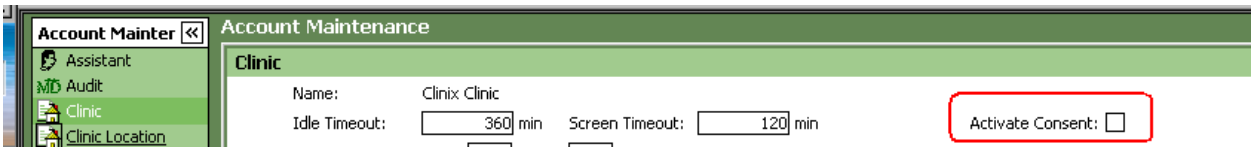
d. Select the *Image Subtype* for the form you are scanning
e. Enter a Description for the form in the Description pane. Add notes if needed in the field provided.
f. Click the *Scan* or *Import* button to import the form.



g. From the Add/Edit Image window, confirm your scan or import and Select **Save** as show below:


Add/Edit Image
Description
Authorization Form
Injection
Orders
Procedure
Cardiovascular
Angioplasty Reports
CABG Reports
Echocardiogram
EKG
Holter Reports
Nuclear Stress
Operative Reports
Stress Test
Consent Form
Informed Concent
Lab
Orders
Patient Demographic
Procedure
RX
Consultations
Cardiology
Endocrinology
ENT
Gastroenterology
Internal Medicine
Nephrology
Image Date: 10/07/2009 12:00 am
Desc: Procedure Form
Notes:
Patient's Name:
Medicare # (HICN):
ADVANCE BENEFICIARY NOTICE (ABN)
NOTE: You need to make a choice about receiving these health care items or services.
We expect that Medicare will not pay for the item(s) or service(s) that are described below.
Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for –
Items or Services:
___Screening Pelvic Exam
___Screening Breast Exam
___Screening Urinalysis
___Screening Hemocult (G0107)
___Thin Prep Smear
___Collection & Handling of Pap Smear
Because:
Frequency Limitations: once every (2) two years for low-risk factors
once every (1) year for high-risk factors
SEE ATTACHED LIST OF HIGH RISK FACTORS
The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare probably won't pay.
Ask us how much these items or services will cost you (Estimated Cost: $ $200.00), in case you have to pay for them yourself or through other insurance.
PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.
Option 1. YES. I want to receive these items or services.
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for
Defaults
Select Medical Image
Scan
Import
Re-Sequence
Print
Delete
Save
Cancel
Help

h. After the scanning or importing process is completed, the form will be added to the list of available Consent forms for the clinic.
i. Repeat steps b – f to add additional forms.
j. If Consent Forms are a clinic requirement, be sure to mark the "Activate Consent" box located in *Settings->Account Maintenance->Clinc:*



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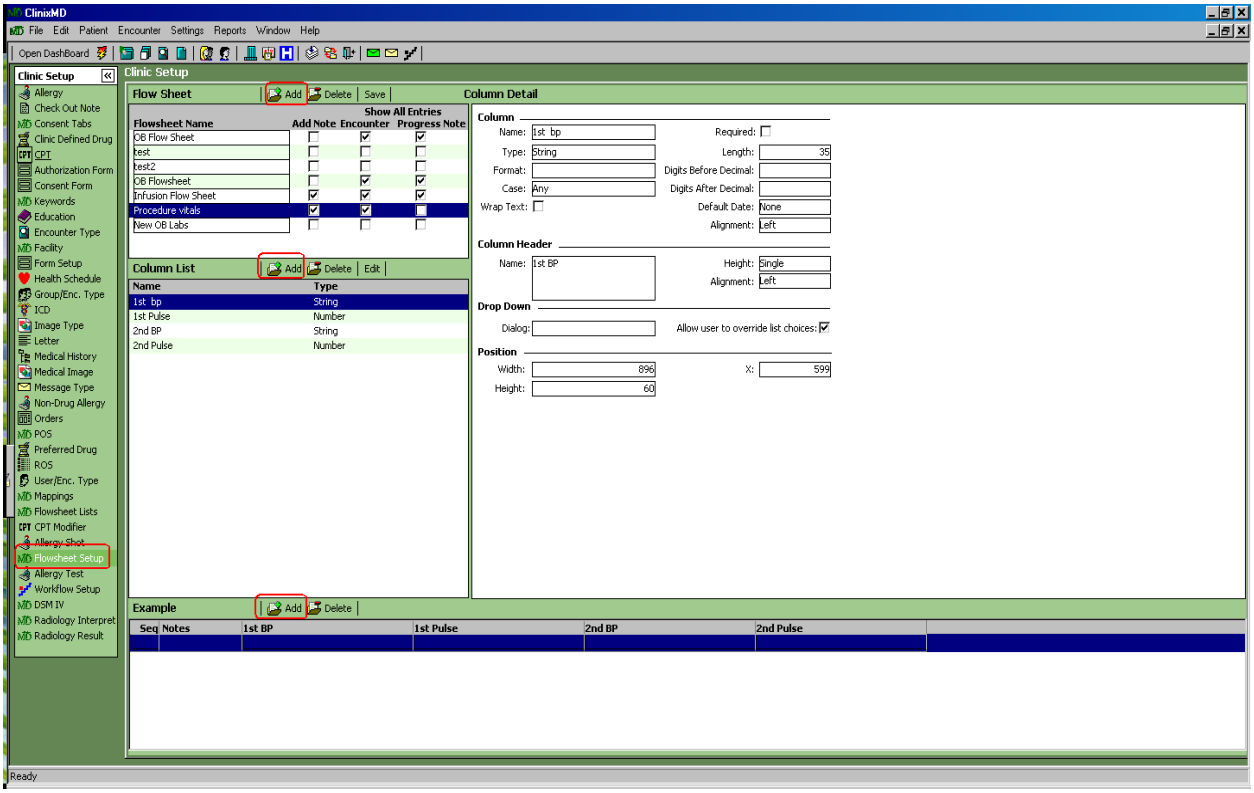
22. FLOWSHEET SETUP

Flowsheets are great tools for tracking specific criteria relative to a plan of care, procedure or treatment.



To create a new Flowsheet, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Flowsheet Setup*
b. Click the "**Add"** button located to the right of **Flow Sheet.**
c. Type in the Flowsheet Name; mark the "Add Note" box to include a free-text note field within the flowsheet, mark the "Encounter" box to include flowsheets in Encounters and mark the "Progress Note" box to include the flowsheet data in your Progress Note (Warning: the formatting of lengthy flowsheets maybe skewed when viewed in the Progress Note).
d. To add the appropriate columns and configure the expected data values, click the "**Add**" button located to the right of **Column List**.
e. In the "Custom Flow Sheet Column Setup" window, enter the column name and select the expected data type (i.e. "Numbers" if data will be number format only, "String" if using number/character combinations, etc.) from the drop-down **Type** list. Mark the "Required" box if the entering data in the specific column of the flowsheet is required and mark the "Wrap Text" box if the data is lengthy. There are also options to increase the character length of each data box (within the column). See image below:

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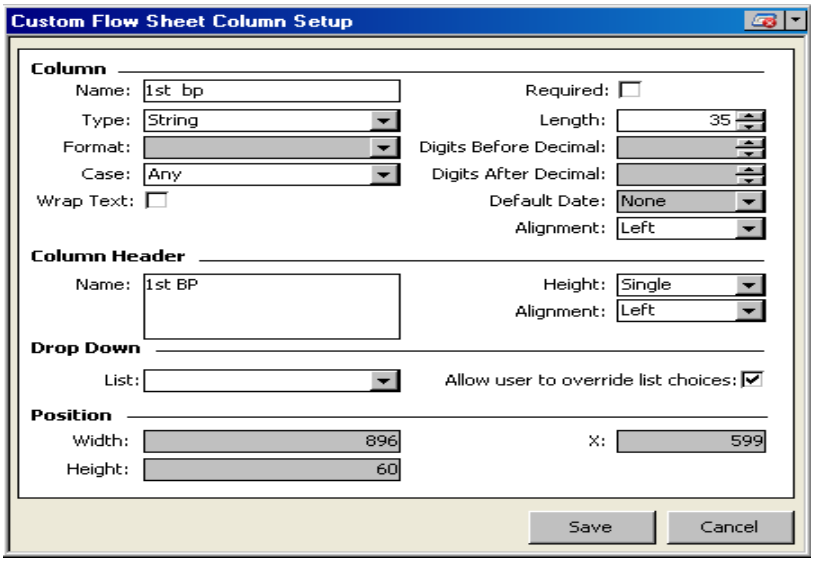
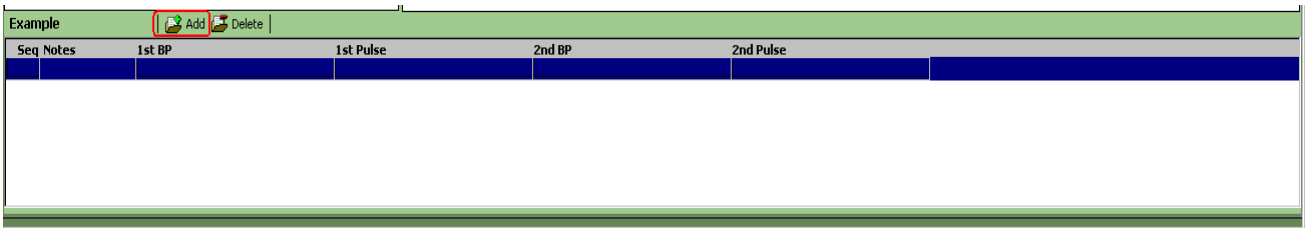


f. The column name will default in the **Column Header** name box; however, it can be modified.
g. Data values can be limited to a specific set using Flowsheet Lists.
h. Click “Save” to save your Custom Column Setup.
i. To add additional columns, repeat steps *d-h.*
j. To view an example of the flowsheet, click the “Add” button located to the right of **Example** at the bottom of the screen and select the applicable flowsheet name.
k. Drag-and-drop the columns in the flowsheet example to change column order.



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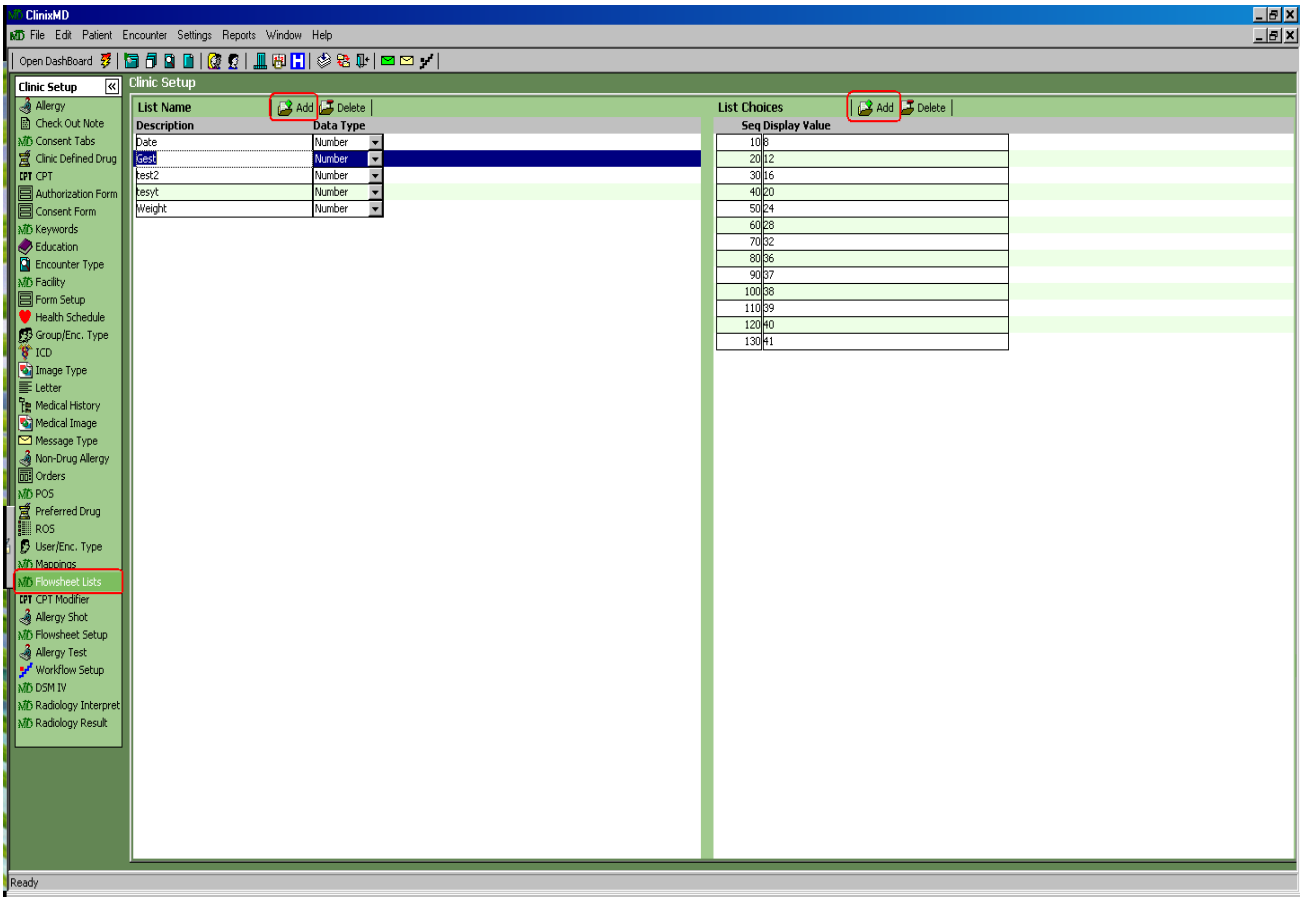
23. FLOWSHEET LISTS

The 'Flowsheet Lists' tab is used to create and store specified data set to be included in any flowsheet column.



To add a flowsheet list, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Flowsheet Lists*
b. Click the "**Add"** button located to the right of **List Name**.
c. Type the flowsheet list name and select the appropriate data type (i.e. Numbers, String, Date, etc.)
d. To add the data values, click the "**Add**" button located to the right of **List Choices** and enter in the value. Continue to build the list using these steps.
e. Click the "**Delete**" located to the right of **List Choices** to delete a specific value and click the "**Delete**" button located to the right of **List Name** to delete an entire list.

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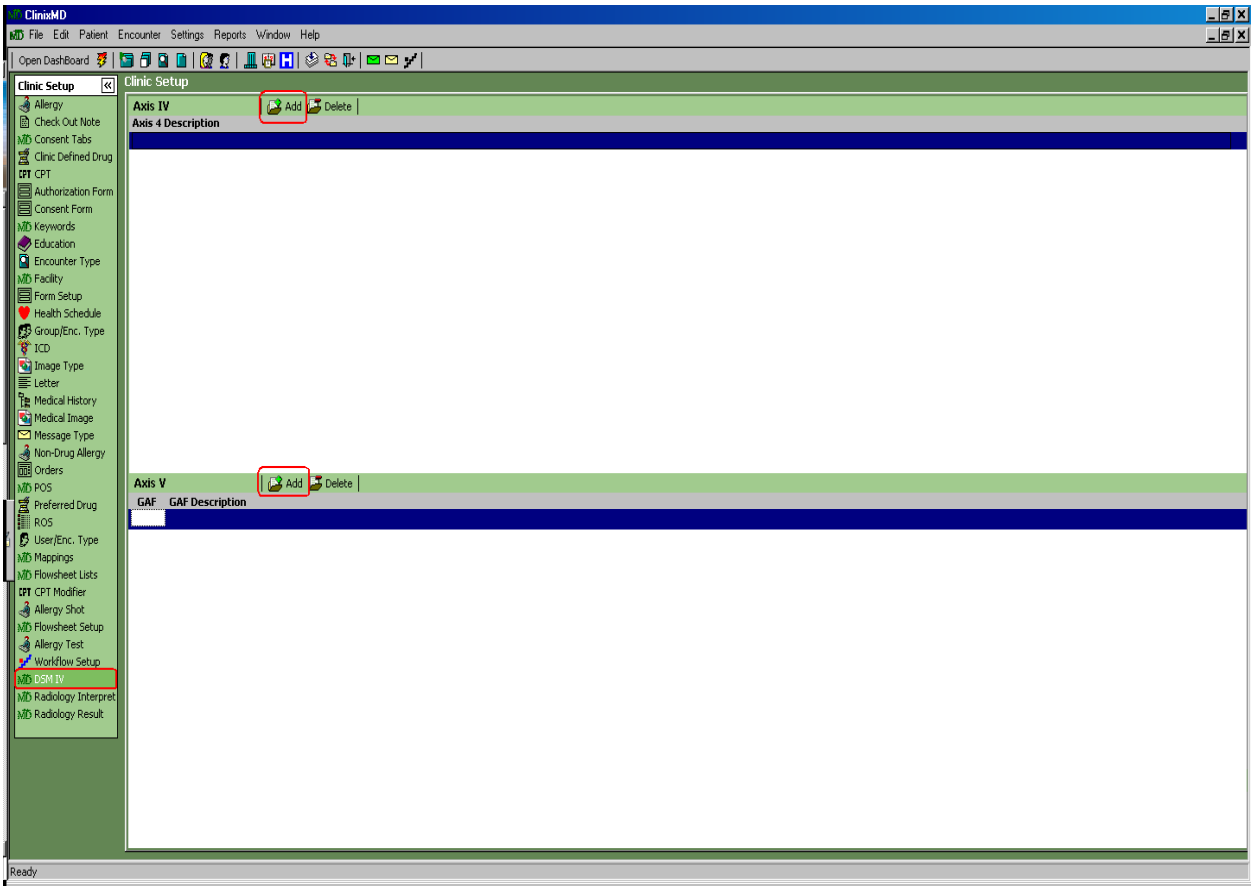
24. DSM IV

The 'DSM IV' tab (Diagnostic and Statistical Manual IV) is used to create Axis IV criteria (Psychosocial and Environmental Stressors) and Axis V scales (Global Assessment of Functioning or GAF).



To add Axis IV and Axis V criteria, follow the steps outlined below:

a. Select *Settings->Clinic Setup->DSM IV*
b. Click the "**Add**" button located to the right of **Axis IV** (upper pane). Enter in the applicable information in the Axis 4 Description free-text field. Right-click to use the "Spell Check" tool.
c. Click the "**Add**" button located to the right of **Axis V** (bottom pane). Enter the applicable GAF score and GAF Description in their respective free-text fields.
d. Repeat steps *b-c* to add additional criteria.

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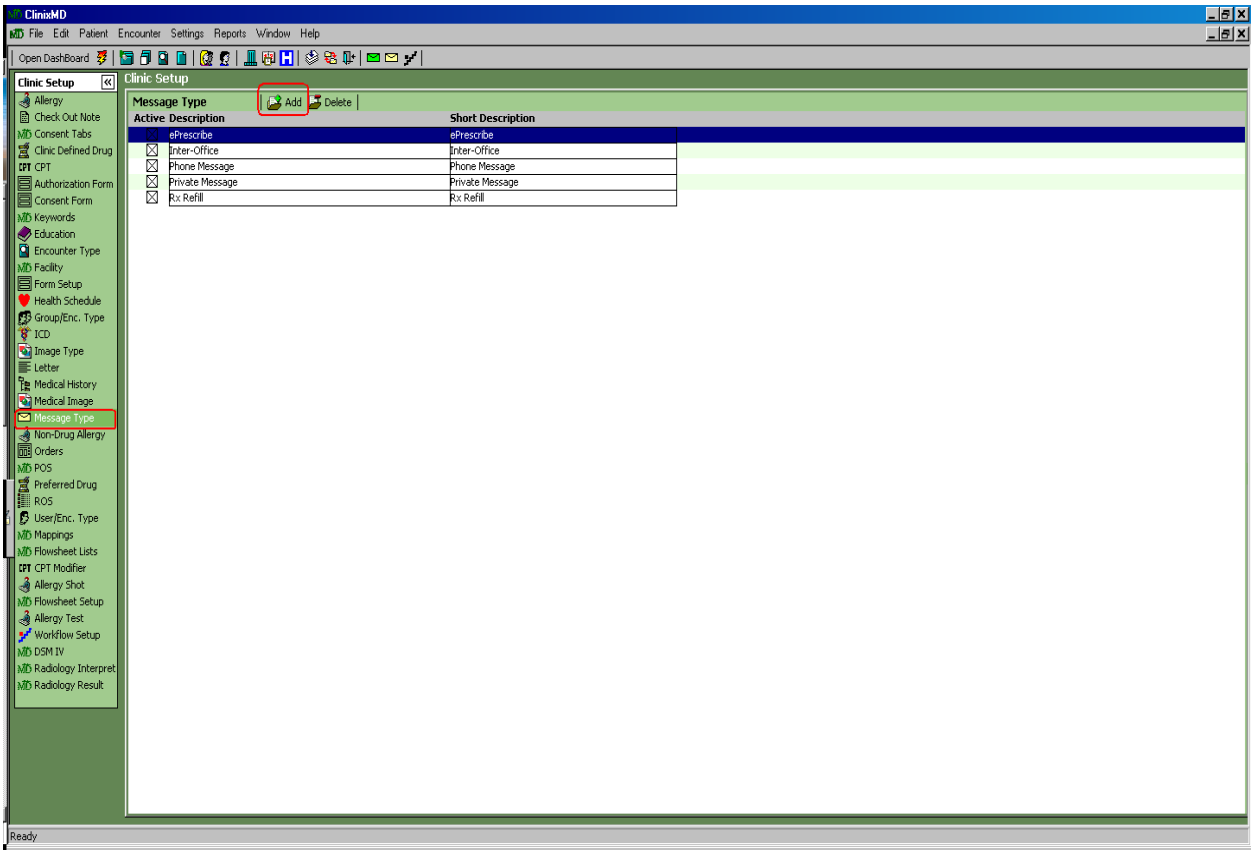
25. MESSAGE TYPE

Several message types are pre-loaded into ClinixMD, including System Messages, Inter-office Messages, ePrescribe Messages, RX Refill Messages and Private Messages. Additional message types can be created in the 'Message Type' tab, depending on your clinic's needs.



To create additional Message Types, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Message Type*
b. Click the "**Add**" button located to the right of **Message Type**.
c. Type the name of the message type in the **Description** and **Short Description** free text fields.
d. Repeat these steps until all desired message types have been added.

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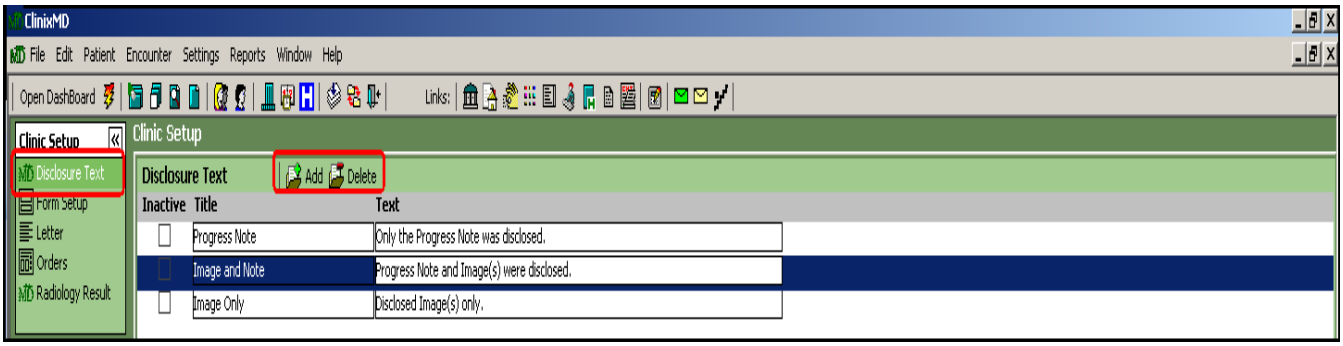
26. DISCLOSURE TEXT

The 'Disclosure Text' tab is used to create the drop-down list of encounter items that are routinely disclosed to external recipients and its corresponding text to be displayed in the 'Disclosure' encounter and patient information tabs as well as in the Progress Note.



To create Disclosure Text items, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Disclosure Text*
b. Click the "**Add**" button located to the right of **Disclosure Text**.
c. Type the name of the disclosure item in the **Title** column and its corresponding text to be displayed in the "Disclosure" Encounter and Patient Information tab in the **Text** free-text field.
d. Repeat these steps until all desired disclosure items have been added.

To remove a Disclosure Text item, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Disclosure Text*
b. If the disclosure item has not been used in an encounter, select the appropriate reason and click the "**Delete**" button.
c. If the disclosure text item *has* been used in an encounter, you will not be able to delete the entry (the system will throw an error). You will only be able to inactivate the item so that the reason cannot be selected. To do so, select the appropriate disclosure item and mark the "**Inactive**" check-box.
d. Repeat these steps until all desired disclosure items have been deleted/inactivated.

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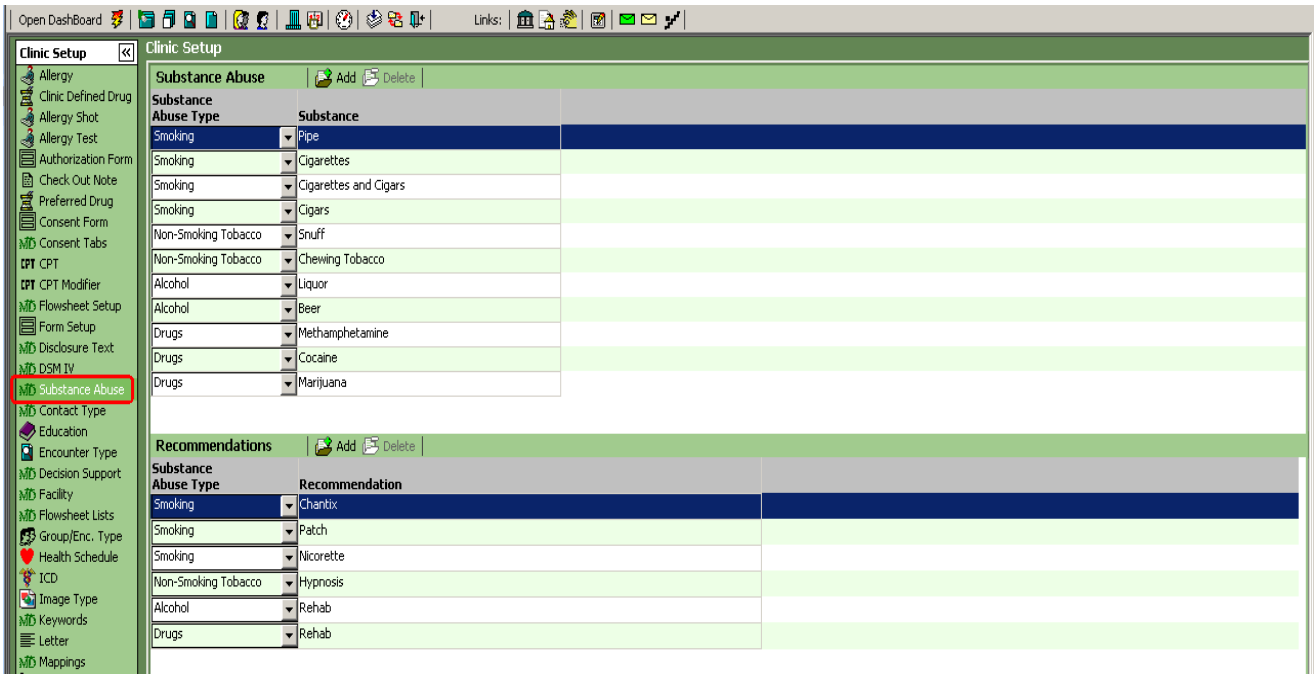
27. SUBSTANCE ABUSE

The 'Substance Abuse' tab is used to add substance items and recommendations; it correlates to the "Substance Abuse" documentation in the 'Medical History' tab in encounters. This information is part of the quality measures reporting mechanism.



To add new Substance Abuse items, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Substance Abuse*
b. Click the "**Add**" button located to the right of **Substance Abuse**.
c. Select the substance abuse type from the drop down list (i.e. drugs, smoking, non-smoking tobacco). In the **Substance** free text field, enter the name of the substance (i.e. snuff, cigars, etc.).
d. Repeat these steps until all desired substance abuse items have been added.

To add new Recommendations, follow the steps outlined below:

a. Click the "**Add**" button located to the right of **Recommendations** (lower pane).
b. Select the substance abuse type from the drop down list (i.e. drugs, smoking, non-smoking tobacco). In the **Recommendations** free text field, enter the name of the recommendation (i.e. hypnosis, Chantix, etc.).
c. Repeat these steps until all desired recommendations have been added.

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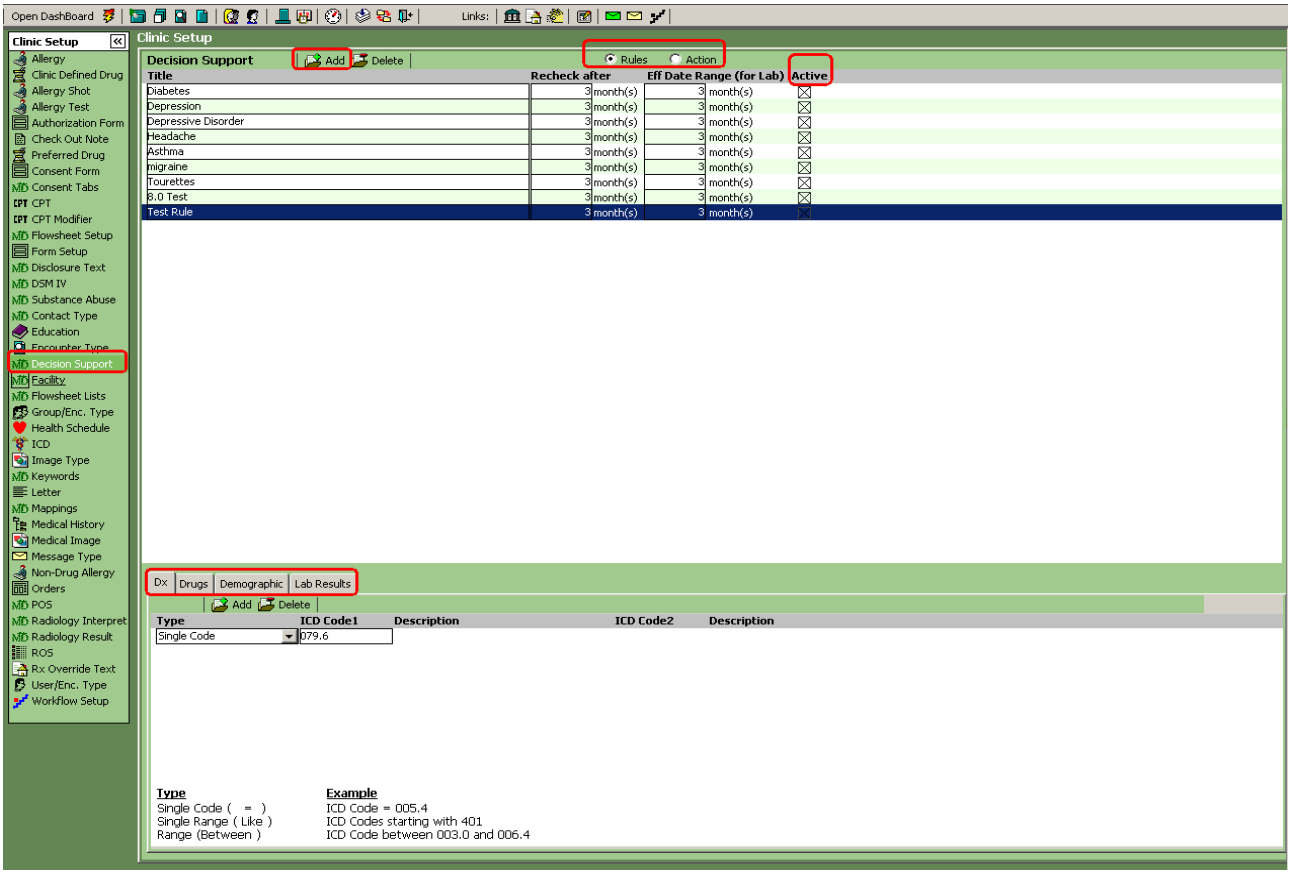
28. DECISION SUPPORT

The 'Decision Support' tab is used to add clinical decision support rules and care suggestions based on the following elements in patients' charts: problem list, medication list, demographics and lab results. These rules provide automatic notifications once the patient is selected.



To add a new Decision Support rule, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Decision Support*
b. Click the "**Add**" button located to the right of **Decision Support**.
c. Type the name of the rule in the **Title** field, enter the **Recheck After** time frame (i.e. the time frame until the system will reevaluate the rule for the patient), the **Eff Date Range** for labs and be sure to mark the "Active" check-mark (do not mark the active box until the rule setup has been completed).

To build the rule, follow the steps outlined below:

a. Select the rule; in the lower pane, add the applicable diagnosis (DX), drug family information (Drugs), demographics and/or lab results. You can choose to select a single element (i.e. Diagnosis only) or a combination of elements (i.e. Diagnosis, Drug Family and Demographic Information) for the rule.

To add an action to the rule, follow the steps outlined below:

a. Select the rule and then select the "Action" radio button.
b. In the lower pane, enter any care suggestions in the "Instruction" tab.
c. In the lower pane, add educational material(s) to be provided to the patient in the "Education" tab. Click the "**Add**" button, then search for and select the applicable educational items to be attached to the rule. Once added, the items can be reviewed by clicking the "View Image" button.

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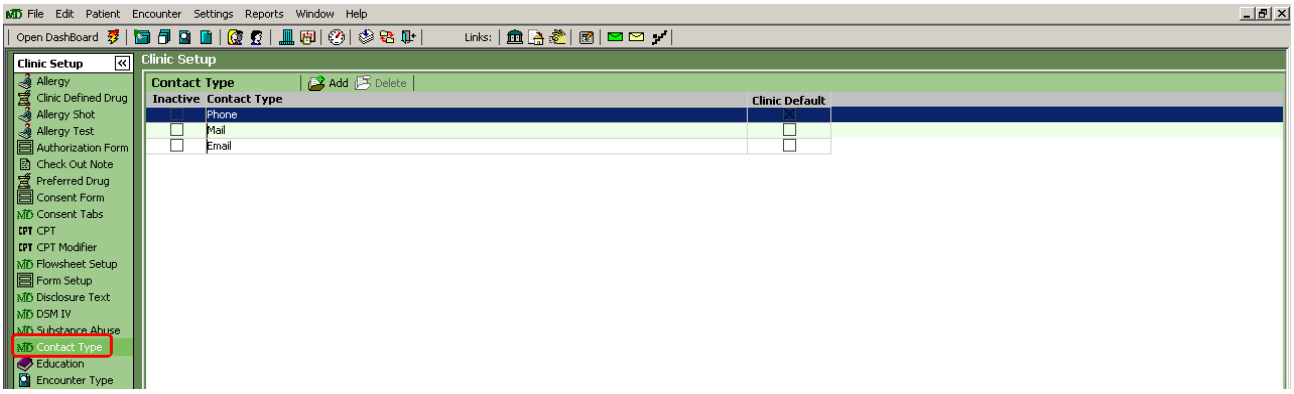
29. CONTACT TYPE

The 'Contact Type' tab is used to add preferred contact methods. The database, as a default, is set-up with the following types: Phone, Mail and Email. "Phone" is the default contact method in the "Demographics" tab within the Patient Information area.



To add a Contact Type, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Contact Type*
b. Click the "**Add**" button located to the right of **Contact Type**.
c. Type the name of the contact type in the free-text **Contact Type** field; if this needs to be the clinic's default type, mark the **Clinic Default** check-box.

To remove a Contact Type, follow the steps outlined below:

a. Select the entry and click the "**Delete**" button (Note: you can only delete entries that you have previously entered and are not attached to a patient; the "phone," "mail" and "email" types cannot be deleted).
b. If the entry cannot be deleted, you can mark it as **Inactive** to remove it from the list of contact types available for selection in the "Demographics" tab in the Patient Information area.

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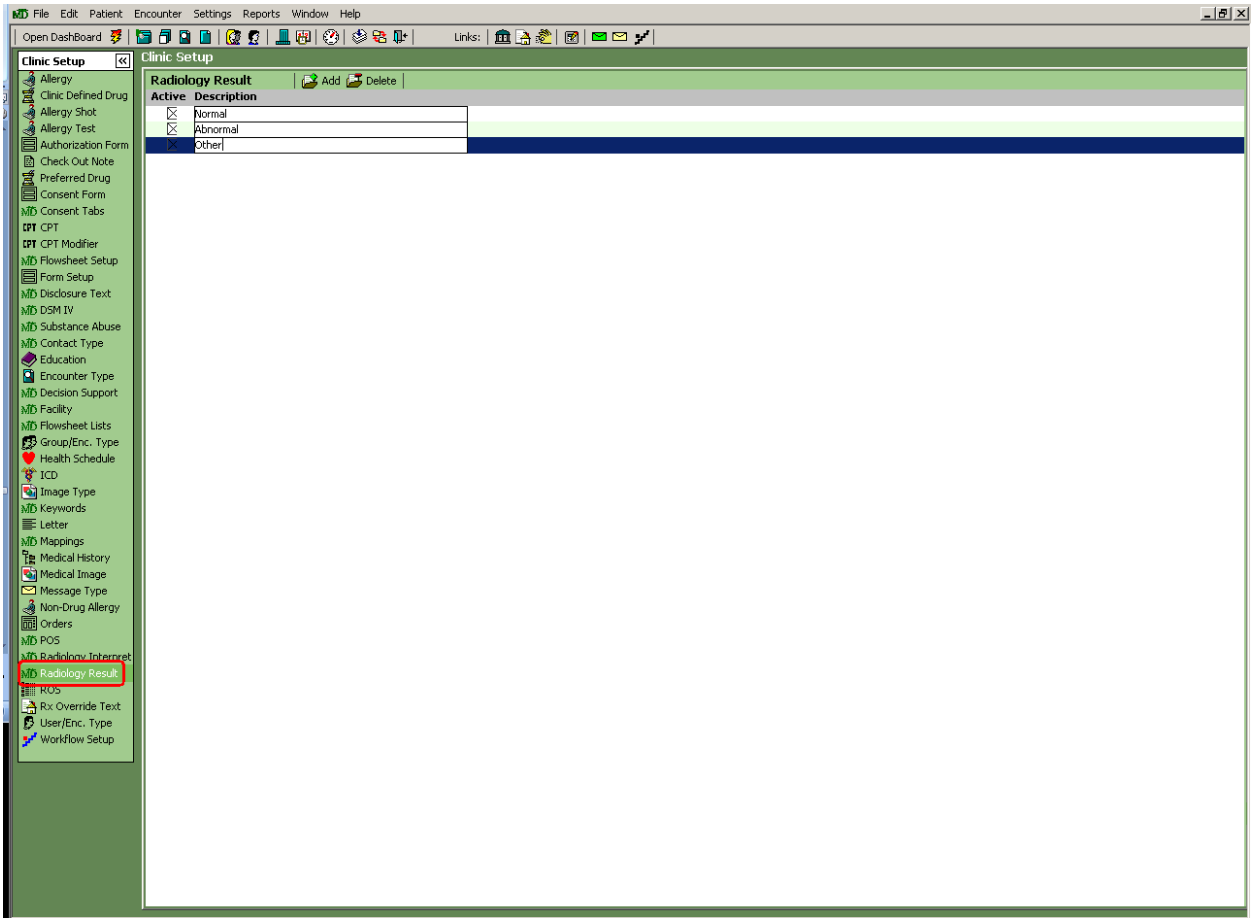
30. RADIOLOGY RESULT

The 'Radiology Result' tab is used to add the default radiology results when adding them manually to ClinixMD (Note: if received via an interface, the results will populate automatically).



To add a Radiology Result, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Radiology Result*
b. Click the "**Add**" button located to the right of **Radiology Result**.
c. Enter the result in the free-text **Description** field.

To remove a Radiology Result, follow the steps outlined below:

a. Select the entry and click the "**Delete**" button.
b. If the entry cannot be deleted, remove the **Active** check-mark to remove the it from the list of radiology results available for selection.

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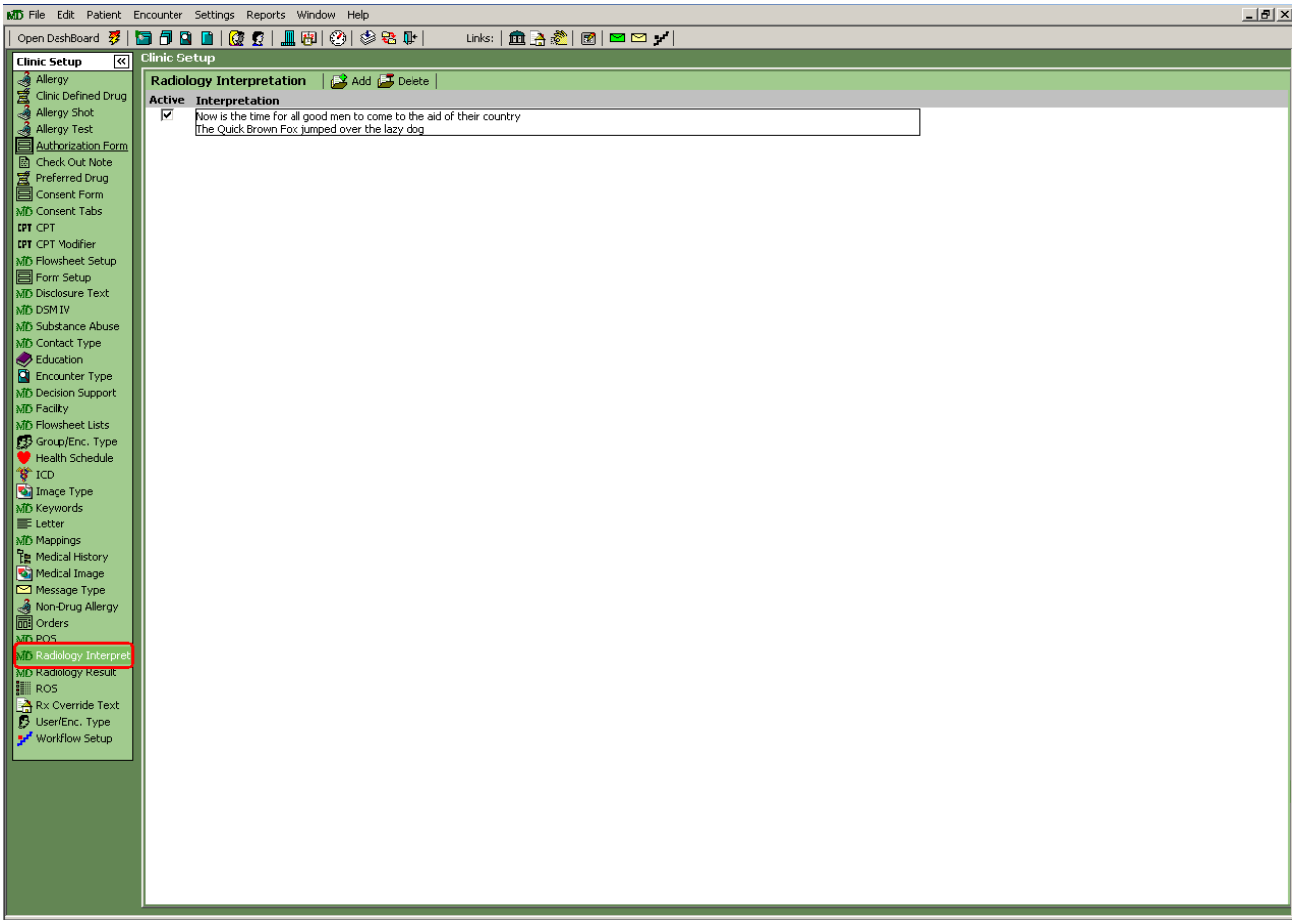
31. RADIOLOGY INTERPRETATION

The 'Radiology Interpretation' tab is used to add the default radiology interpretations when manually adding radiology results.



To add a Radiology Interpretation, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Radiology Interpretation*
b. Click the "**Add**" button located to the right of **Radiology Result**.
c. Enter the result in the free-text **Description** field.

To remove a Radiology Interpretation, follow the steps outlined below:

a. Select the entry and click the "**Delete**" button.
b. If the entry cannot be deleted, remove the **Active** check-mark to remove the it from the list of radiology interpretations available for selection.

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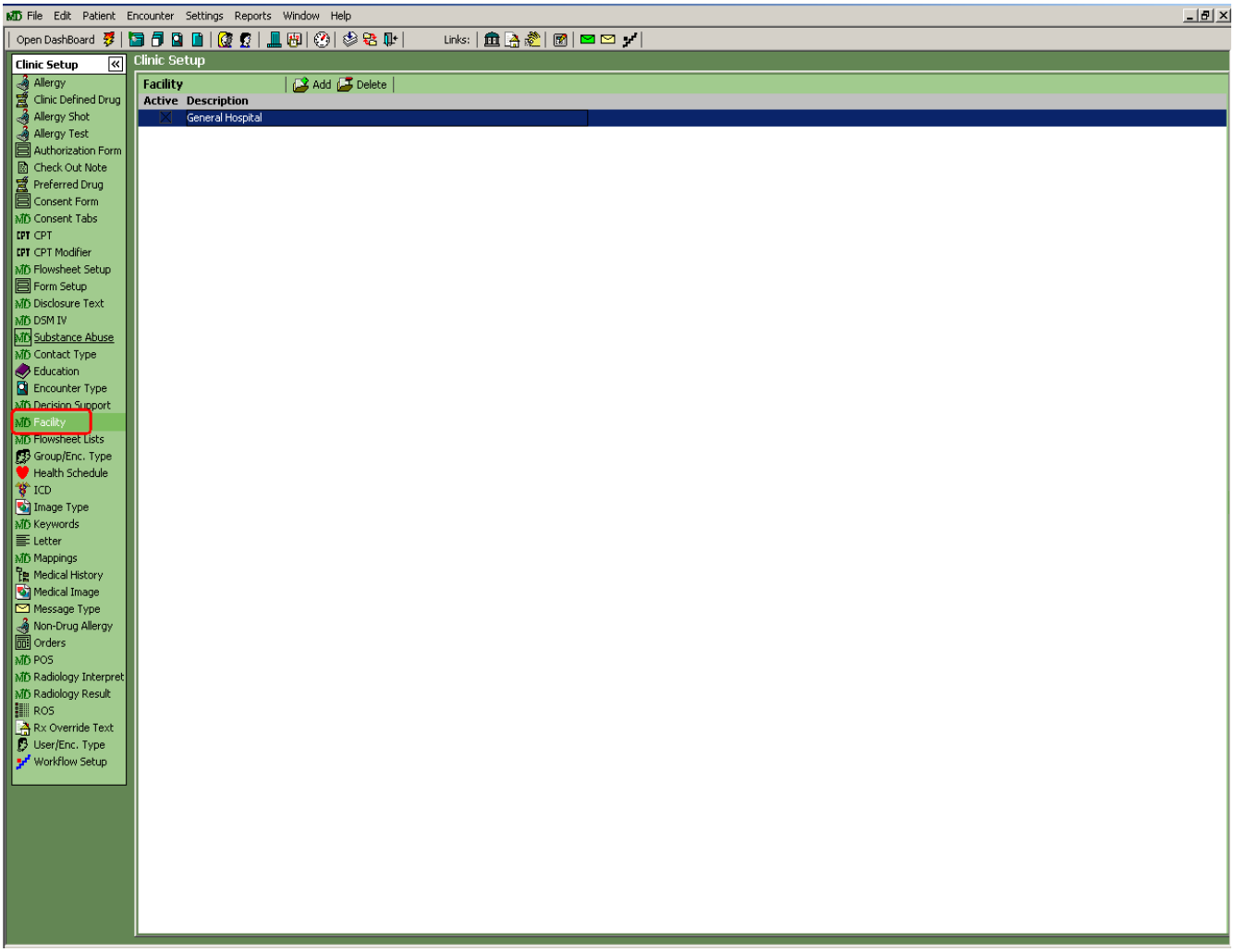
32. FACILITY

The 'Facility' tab is used to create the facility list for the clinic. These facilities are used when charting hospital rounds.



To add a Facility, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Facility*
b. Click the "**Add**" button located to the right of **Facility**.
c. Enter the name of the facility in the free-text **Description** field.

To remove a Facility, follow the steps outlined below:

a. Select the entry and click the "**Delete**" button.
b. If the entry cannot be deleted, remove the **Active** check-mark to remove the it from the list of facilities available for selection.

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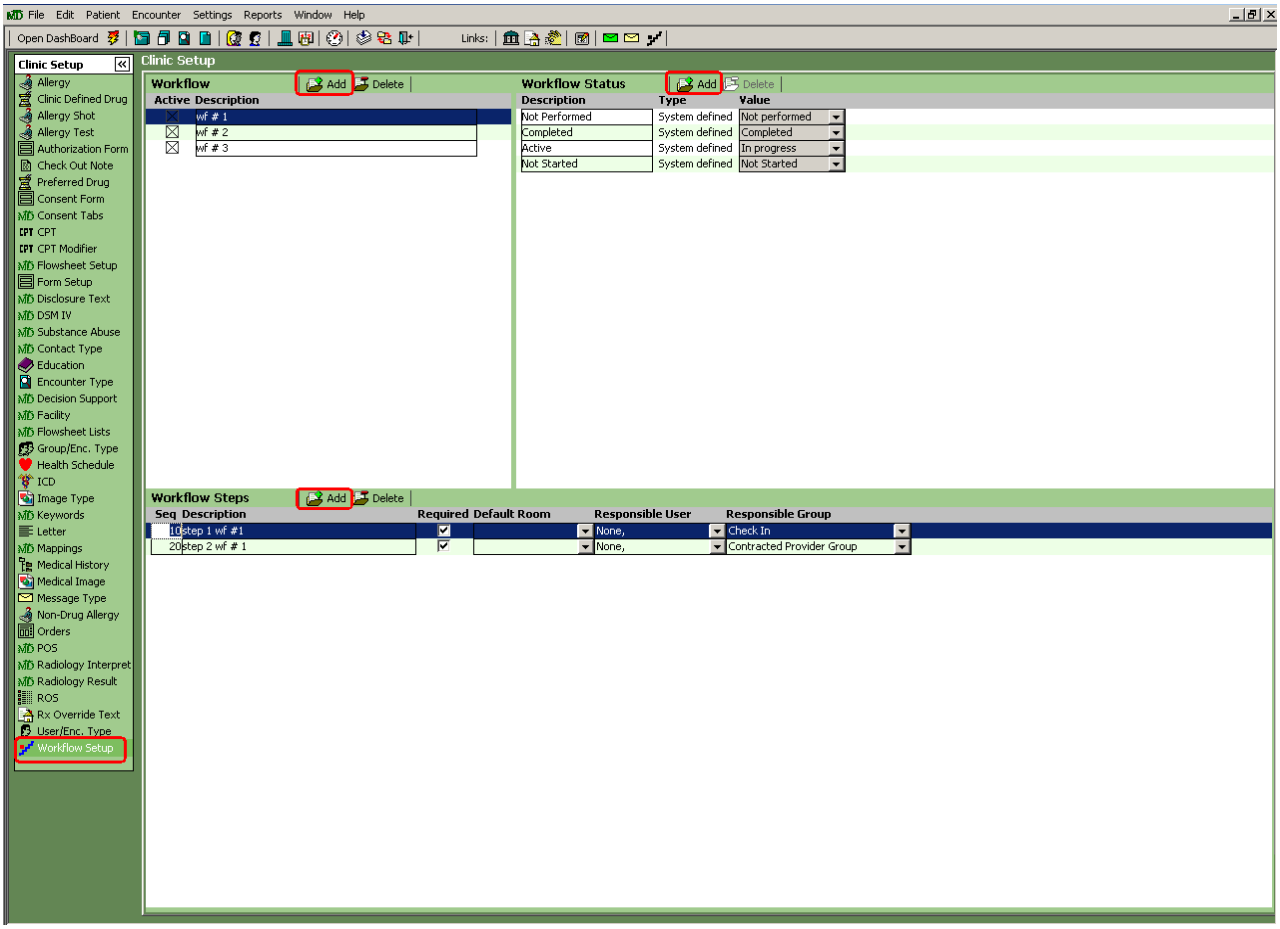
33. WORKFLOW

The 'Workflow' tab is used to build task workflows for the office. Elements include each step necessary to complete the task, task status and responsible user/group. Several workflow statuses are system defined but additional statuses can be added to suit your clinic's needs. Note: Once assigned to a patient, workflows cannot be deleted; however, they can be inactivated so that they are no longer available for use. To inactivate a workflow, remove the mark in the **Active** check-box.



To create a new Workflow, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Workflow Setup*
b. Click the **Add** button located to the right of **Workflow**.
c. Enter the name of the workflow in the **Description** field.
d. In the lower pane, click the **Add** button located to the right of **Workflow Steps**.
e. Enter the name of the first task in the **Description** field, mark the **Required** check-box if the step is mandatory, assign a clinic room in the **Default Room** drop-down list (i.e. lab) and then assign either a **Responsible User** or **Responsible Group**.
f. Repeat steps d and e until all workflow tasks have been created.

To add new Workflow Statuses, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Workflow Setup*
b. Click the **Add** button located to the right of **Workflow Status**.
c. Enter the name of the status in the **Description** field.
d. Select the status **Value** using the drop-down list (these are system defined and cannot be changed).

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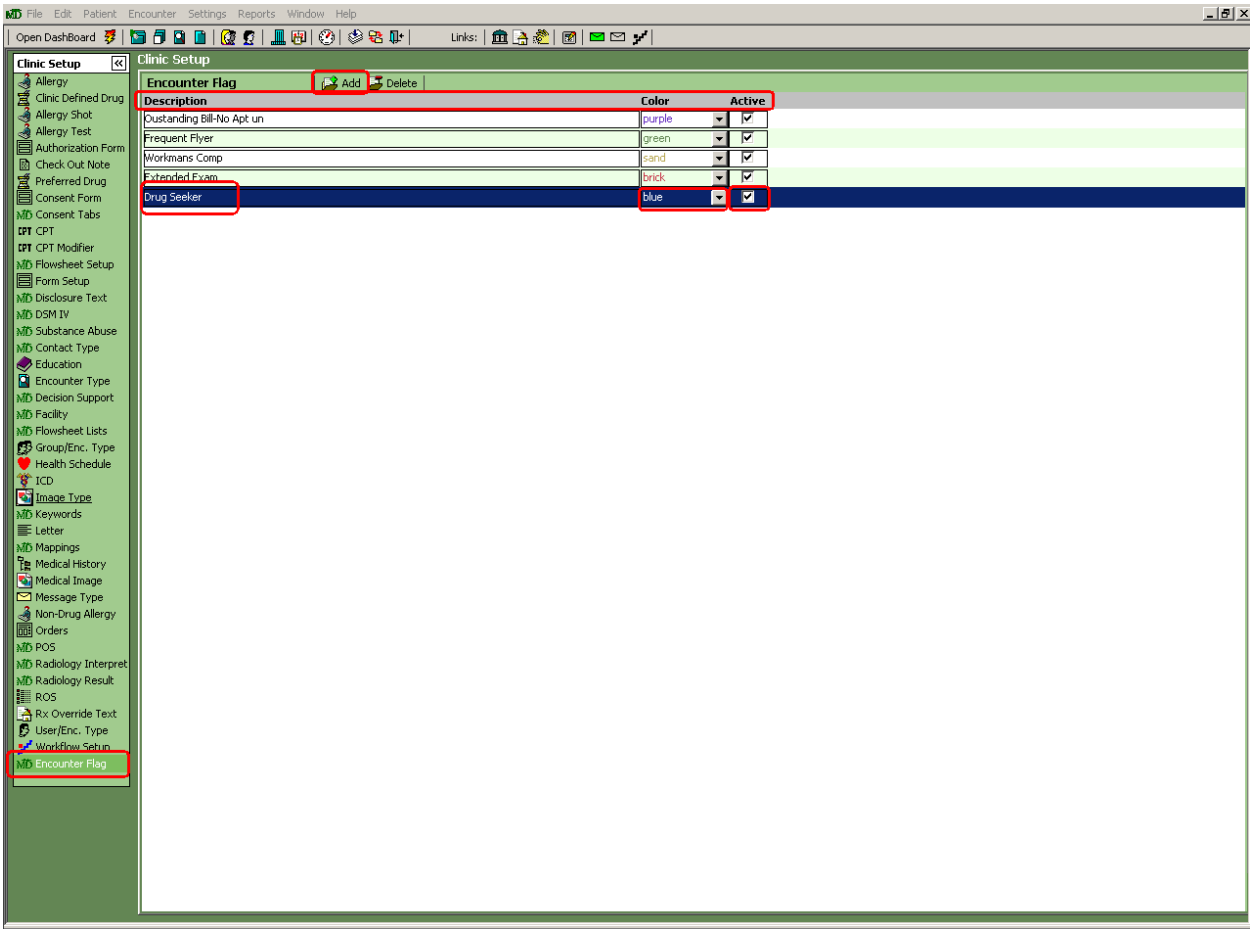
34. ENCOUNTER FLAG

The 'Encounter Flag' tab is used to create the various encounter level flags in your office. They can be used to flag a patient's specific billing needs, to flag a patient that is a possible drug-seeker, etc. Note that because this is at the encounter level, it will need to be set to a specific encounter and is not automatically applied to future encounters.



To create a new Encounter Flag, follow the steps outlined below:

a. Select *Settings->Clinic Setup->Encounter Flag*
b. Click the **Add** button located to the right of **Encounter Flag**.
c. Enter the name of the flag in the **Description** field.
d. Select the flag **Color** from the drop-down list.
e. Mark the **Active** check-box.
f. Click "F5" on your keyboard to save changes. To immediately delete a flag, click the **Delete** button. Once a flag has been assigned to an encounter, it cannot be deleted it can only be inactivated. To inactivate a flag, *remove* the **Active** check-mark.
g. Repeat steps b - f until all desired flags have been created.

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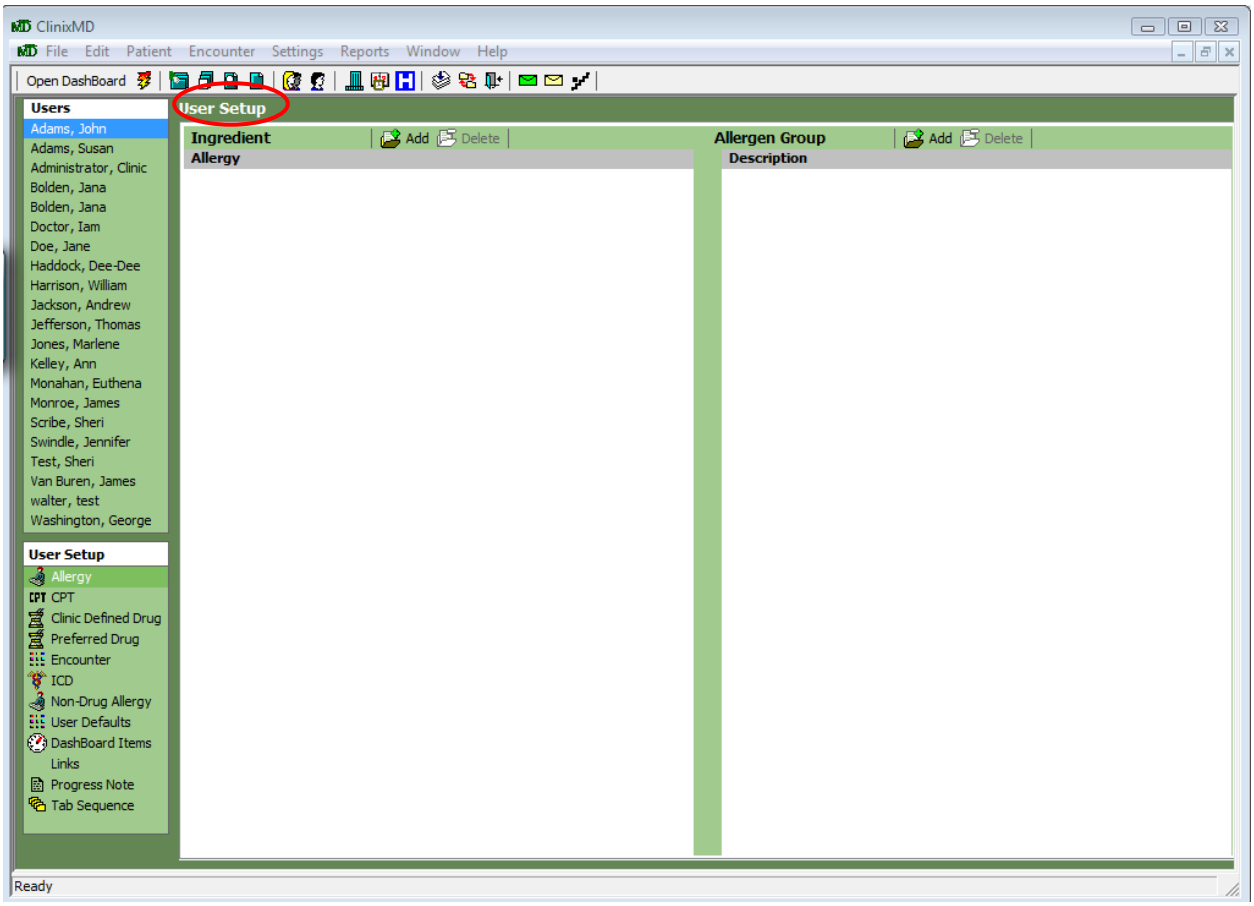
USER SETUP

The 'User Setup' section contains all the tabs that can be configured for specific users. Customizing search and other settings facilitates the common tasks performed by users. Customizing users' lists and settings also reduces the errors that commonly occur. The administrator can customize the application in the User Setup section so that only the information that is necessary to specific clinic roles appears for a given staff member.



This section will cover the following tabs that make up the User Setup window:

1. ICD
2. CPT
3. Allergy
4. Non-Drug Allergy
5. Preferred Drug
6. Encounter
7. User Defaults
8. Tab Sequence
9. Links

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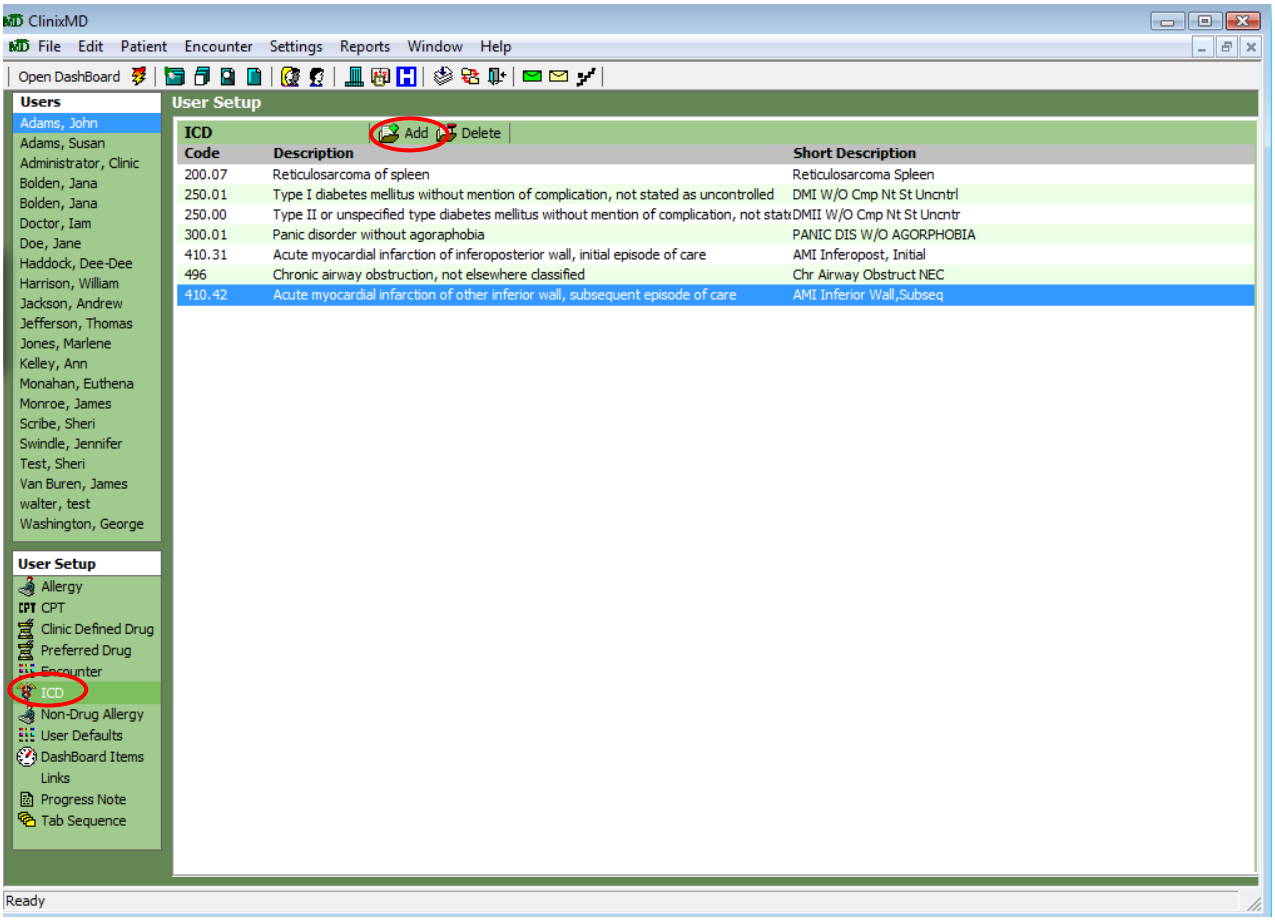
1. ICD

The 'ICD' tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the User List. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to "Clinic."



To add an ICD code to the User List, follow the steps outlined below:

a. Select *Settings->User Setup->ICD.*
b. Highlight the *name of the user* you want to use in customizing your list by clicking on the name in the User pane.
c. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu to add a new ICD to the user list. A search window displays with the Clinic setting selected in the Preferred List.

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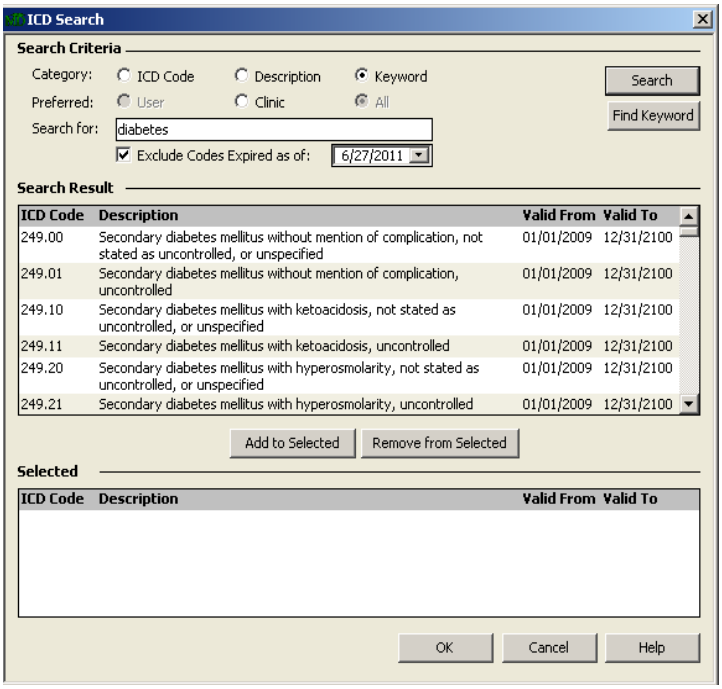
d. Select the search criteria using the radio buttons provided. Options include ICD Code, Description or Keyword.
e. Enter partial or complete information in the search fields.
f. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the “Exclude codes....” check-box.
g. Click the **Search** button. A list of results display in the Search Results pane.
h. Select one or more ICD codes and click the **Add to Selected** button. The items selected appear in the lower pane labeled *Selected.* See figure below.


ICD Search
Search Criteria
Category: ICD Code Description Keyword
Preferred: User Clinic All
Search for: diabetes
Exclude Codes Expired as of: 6/27/2011
Search
Find Keyword
Search Result
ICD Code Description Valid From Valid To
249.00 Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.01 Secondary diabetes mellitus without mention of complication, uncontrolled 01/01/2009 12/31/2100
249.10 Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.11 Secondary diabetes mellitus with ketoacidosis, uncontrolled 01/01/2009 12/31/2100
249.20 Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified 01/01/2009 12/31/2100
249.21 Secondary diabetes mellitus with hyperosmolarity, uncontrolled 01/01/2009 12/31/2100
Add to Selected
Remove from Selected
Selected
ICD Code Description Valid From Valid To
OK
Cancel
Help

i. Click *OK* to complete the process. All ICD Codes Selected appear in the ICD tab and will be available to the user you selected when that user performs a ICD code search

***Note: You can remove any of the selected items by highlighting the items and clicking the *Remove from Selected* button.**

To delete an ICD code from the User List, follow the steps outlined below:

a. Select *Settings->User Setup->ICD.*
b. From the ICD Code tab, highlight the *ICD* code you want to delete.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK*.

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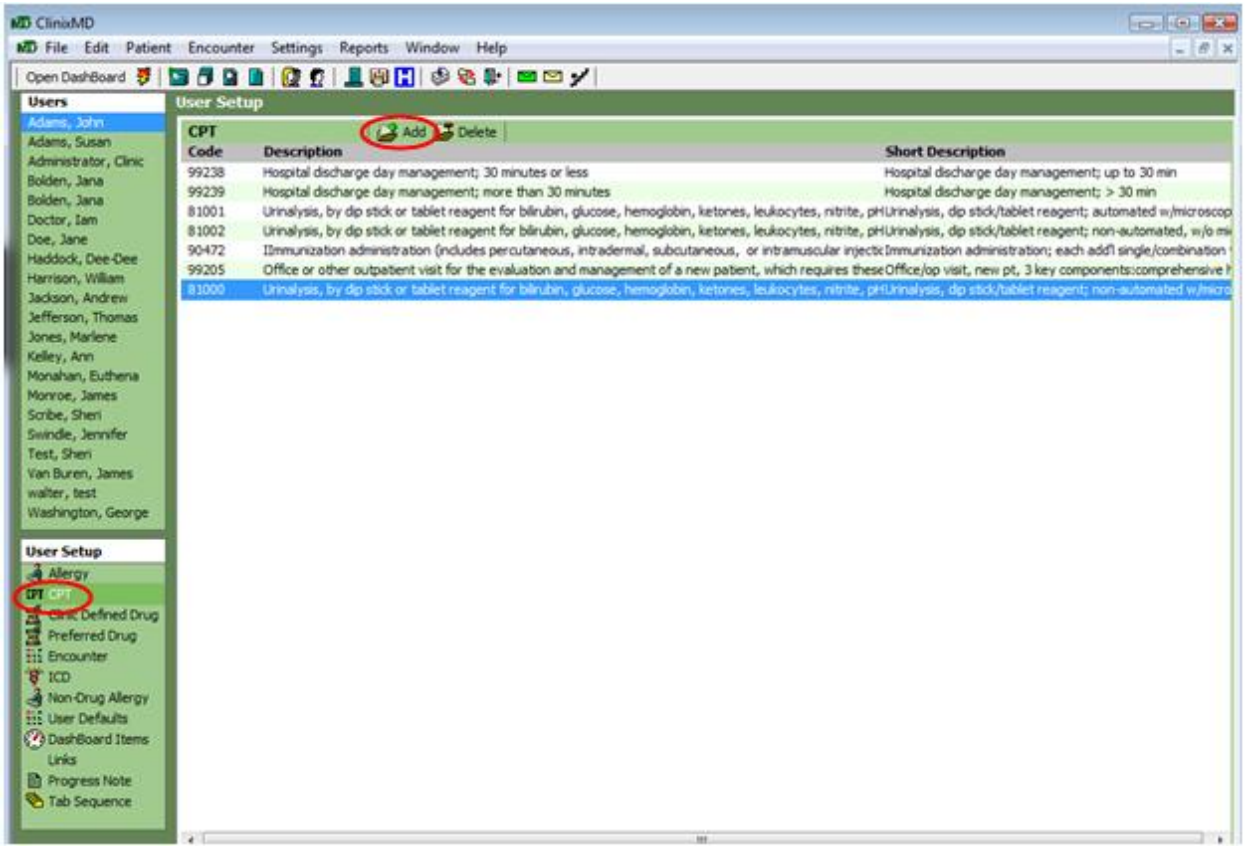
2. CPT

The 'CPT' tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the user list. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to "Clinic."



To add a CPT to the User List, follow the steps outlined below:

a. Select *Settings->User Setup->CPT*
b. Select the appropriate user name.
c. Click the **Add** button located to the right of **CPT**.
d. In the "CPT Search" window, select your search category: CPT Code, Description or Keyword.
e. Depending on the search category, enter either complete or partial code/description along with the '%.' You can also enter a keyword(s) (i.e. diabetes).
f. Either set the code expiration date using the drop-down calendar tool (to filter codes that are only valid until the date selected) or un-check the "Exclude codes...." check-box.
g. Click the **Search** button to begin the search. A list of results appears in the Search Results pane.
h. Select one or more of the *CPT* Codes from the Search Results pane by clicking them.
i. Click the **Add to Selected** button. This action places the CPT codes you selected in the lower pane labeled *Selected.* See figure below:

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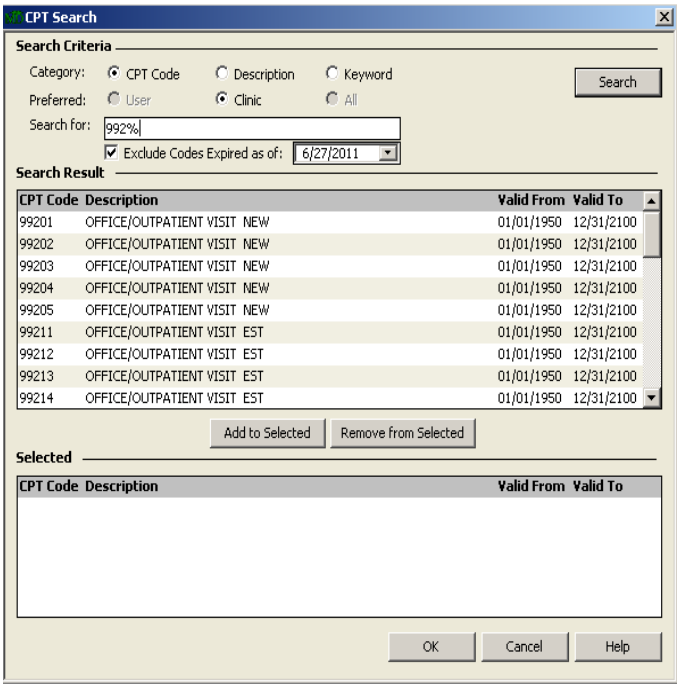
CPT Search
Search Criteria
Category: CPT Code Description Keyword
Preferred: User Clinic All
Search for: 992%
Exclude Codes Expired as of: 6/27/2011
Search
Search Result
CPT Code Description Valid From Valid To
99201 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99202 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99203 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99204 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99205 OFFICE/OUTPATIENT VISIT NEW 01/01/1950 12/31/2100
99211 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99212 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99213 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
99214 OFFICE/OUTPATIENT VISIT EST 01/01/1950 12/31/2100
Add to Selected
Remove from Selected
Selected
CPT Code Description Valid From Valid To
OK
Cancel
Help

j. Click *OK* to complete the process. All CPT Codes Selected appear in the CPT tab and will be available to the user you selected when that user performs a CPT code search.

***Note: You can remove any of the selected items by highlighting the items and clicking the *Remove from Selected* button.**

To delete a CPT code from the User List, follow the steps outlined below:

a. Select *Settings->User Setup->CPT.*
b. Click on the *CPT* code you want to delete form the list.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box appears.
d. Confirm your deletion by clicking *OK*.

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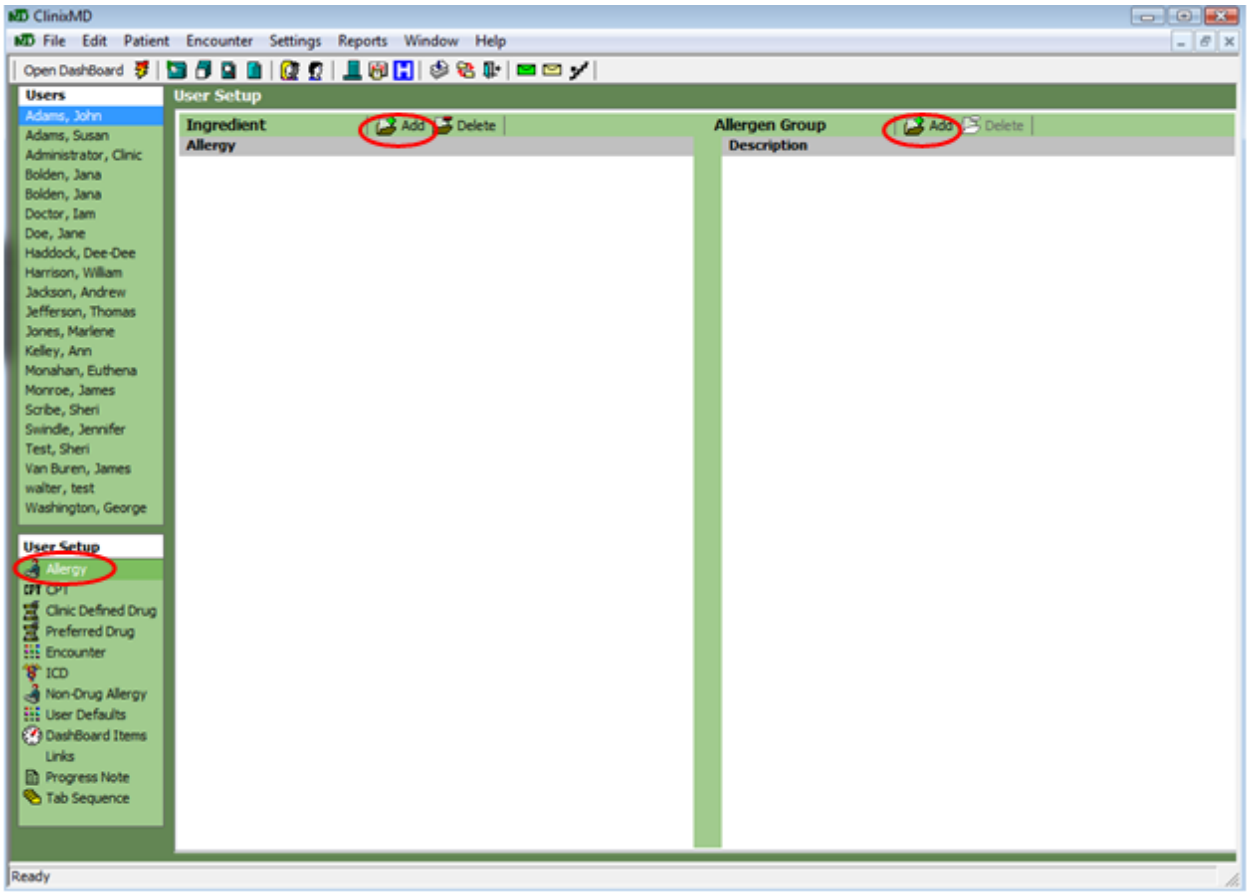
3. ALLERGY

The 'Allergy' tab in this section is used to create a standardized list for a specific user. The administrator can customize a list for a user to facilitate that user's allergy searches. Once the administrator has created this list, it will become the default list for that user. All tabs in this window contain the Users pane that shows all ClinixMD users. By selecting a specific user from the list, the administrator can tailor this information for each user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to "Clinic."



To add an Allergy to a User List, follow the steps outlined below:

a. Select *Settings->User Setup->Allergy.*
b. Highlight the *User* you want to use in customizing their list by clicking the *User* in the Users pane.
c. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu to add a new Allergy to the User List. A search window displays with the Clinic setting Selected in the Preferred List as shown below:

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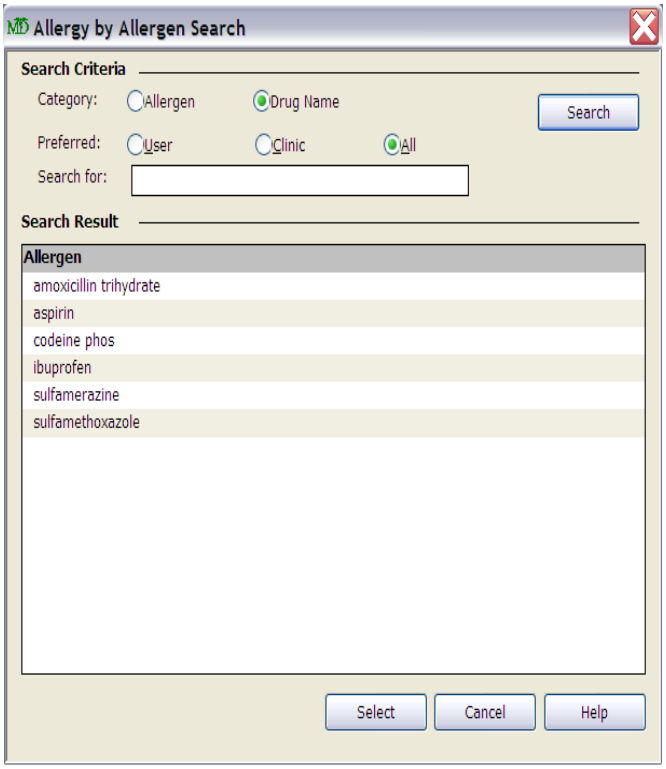

d. Use the Description field to enter partial or complete information about the Allergen you want.
e. Click the **Search** button to begin your search. One or more items display in the Results pane.
f. Highlight your selection and click the Select button.
g. Repeat steps b – f to customize the list for a specific user. Once created, this list will be the default list for the user.

***Note: You can remove any of the selected items by highlighting the items and clicking the *Remove from Selected* button.**

To delete an Allergy from a Users List, follow the steps outlined below:

a. Select *Settings->User Setup->Allergy.*
b. From the Allergy tab, highlight the *Allergen* you want to remove.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A Confirmation dialog box displays.
d. Confirm your deletion by clicking *OK*.

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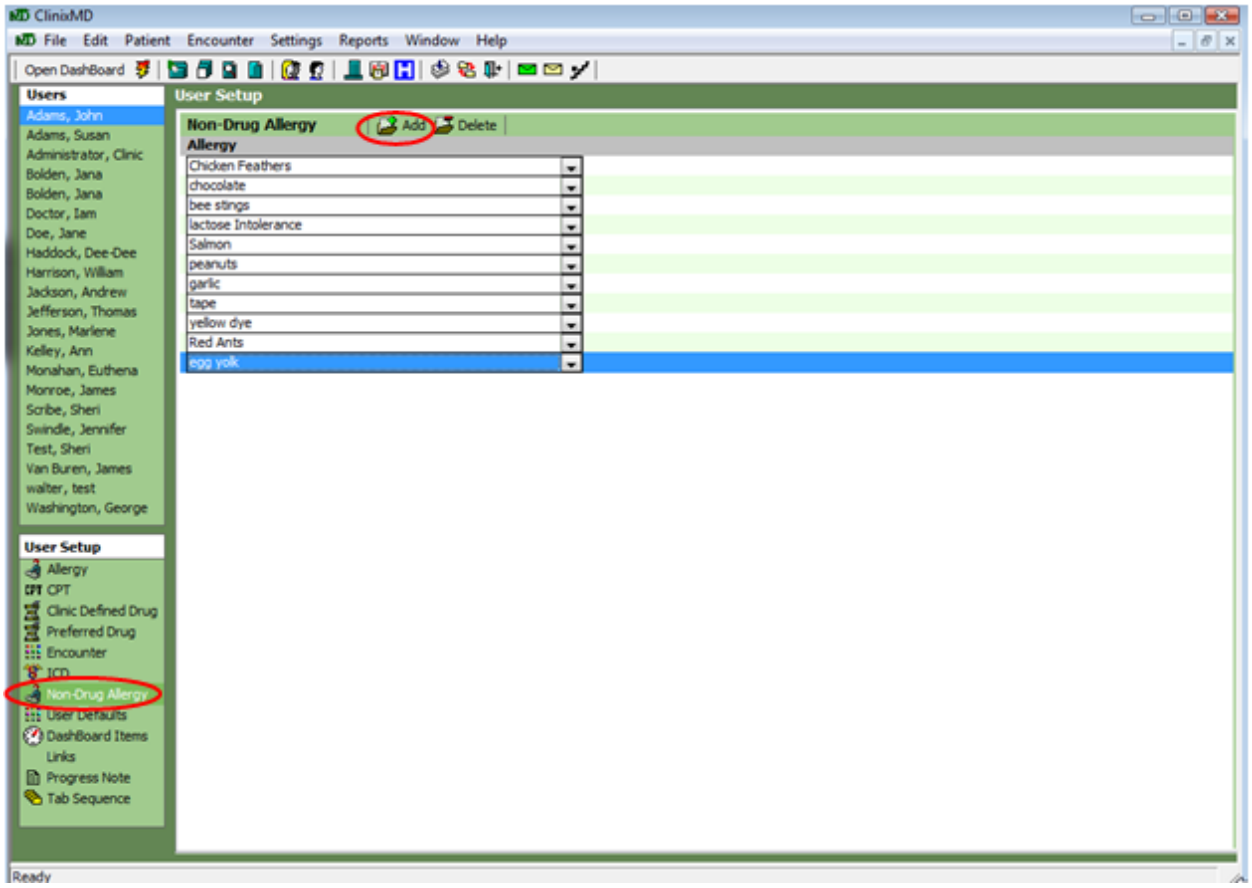
4. NON-DRUG ALLERGY

The 'Non-Drug Allergy' tab in this section is used to create a standardized list for a specific user. The administrator can customize a list for a user to facilitate that user's allergy searches. Once the administrator has created this list, it will become the default list for that user. The administrator can only populate the "User" list with items found in the "Clinic" list (cannot add from the "All" list).



To add a Non-Drug Allergy from the User List, follow the steps outlined below:

a. Select *Settings->User Setup->Other Allergy.*
b. Highlight the user you want to work with from the Users pane.
c. From the Non-Drug Allergy tab, click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays with a drop-down list box.
d. Make a selection from the drop-down list to customize the selected user's list.
e. Repeat the steps above to add additional list items.

To delete a Non-Drug Allergy from the User List, follow the steps outlined below:

a. Select *Settings->User Setup->Other Allergy.*
b. From the Non-Drug Allergy tab, highlight the *allergy* you want to delete.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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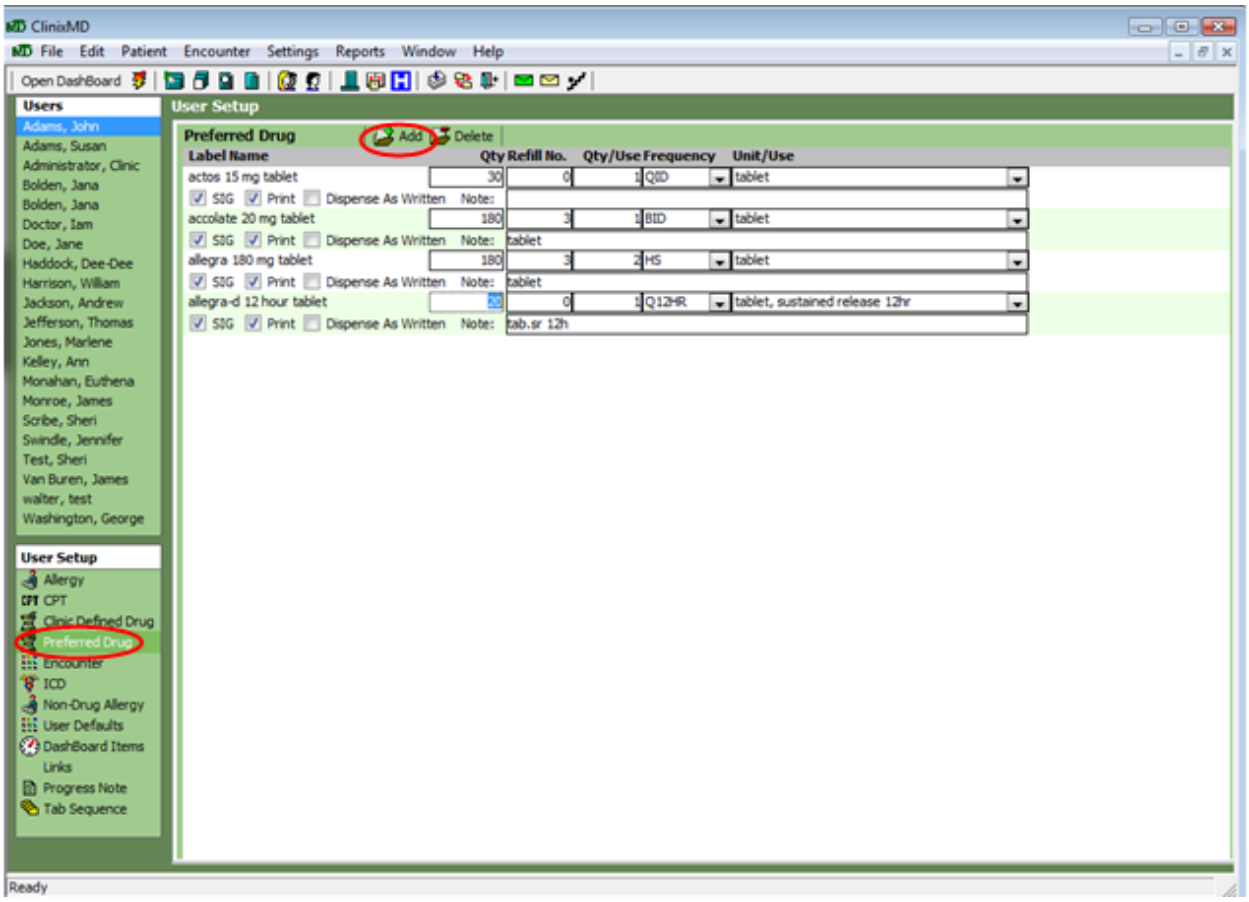
5. PREFERRED DRUG

The 'Preferred Drug' tab is used to customize a list for a specific user. The administrator can create lists for specific users. This list is a condensed version of the Clinic list that applies to all users. Only the items found in the Clinic list can be used to customize the user list. Once the administrator has created this list, it will become the default list for the user. The administrator can only populate the user list with items found in the clinic list. You will notice that when the search window displays, the preferred list settings is always set to Clinic.



To add a Preferred Drug to the User List, follow the steps outlined below:

a. Select *Settings->User Setup->Preferred Drug.*
b. Select the appropriate user name.
c. Click the **Add** button located to the right of **Preferred Drug.** The "Drug Search" pop-up window is displayed.
e. Use the radio buttons to select a search criteria field; options are Label Name or Generic Name.
f. Enter partial or complete information in the *Search For* field.
g. Click the **Search** button to begin the search. A list of results appears in the *Search Result* pane (see image below):

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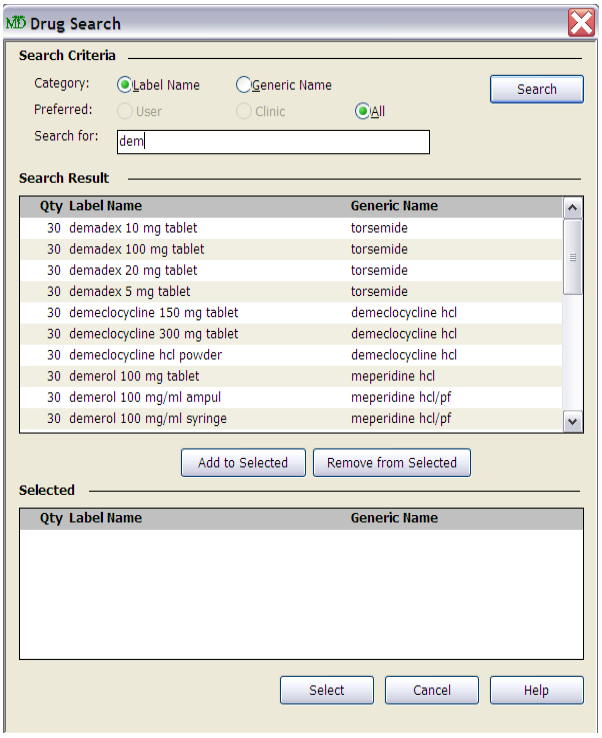

h. Select one or more drug codes and click the **Add to Selected** button. The items selected appear in the lower pane labeled *Selected.*
i. All Preferred Drugs selected appear in the Preferred Drug tab and will be available to that specific user when he/she performs a Preferred Drug search.
j. Once the drug is selected, it displays in the Preferred Drug tab with a pre-filled amount in the Quantity column. Fill in the appropriate information for the frequency using the drop-down list box.
k. Enter any notes for the drug as necessary.

To delete a Preferred Drug from the User List, follow the steps outlined below:

a. Select *Settings->User Setup->Drug Name*
b. From the Preferred Drug tab, highlight the drug you want to delete.
c. Click the **Delete** button on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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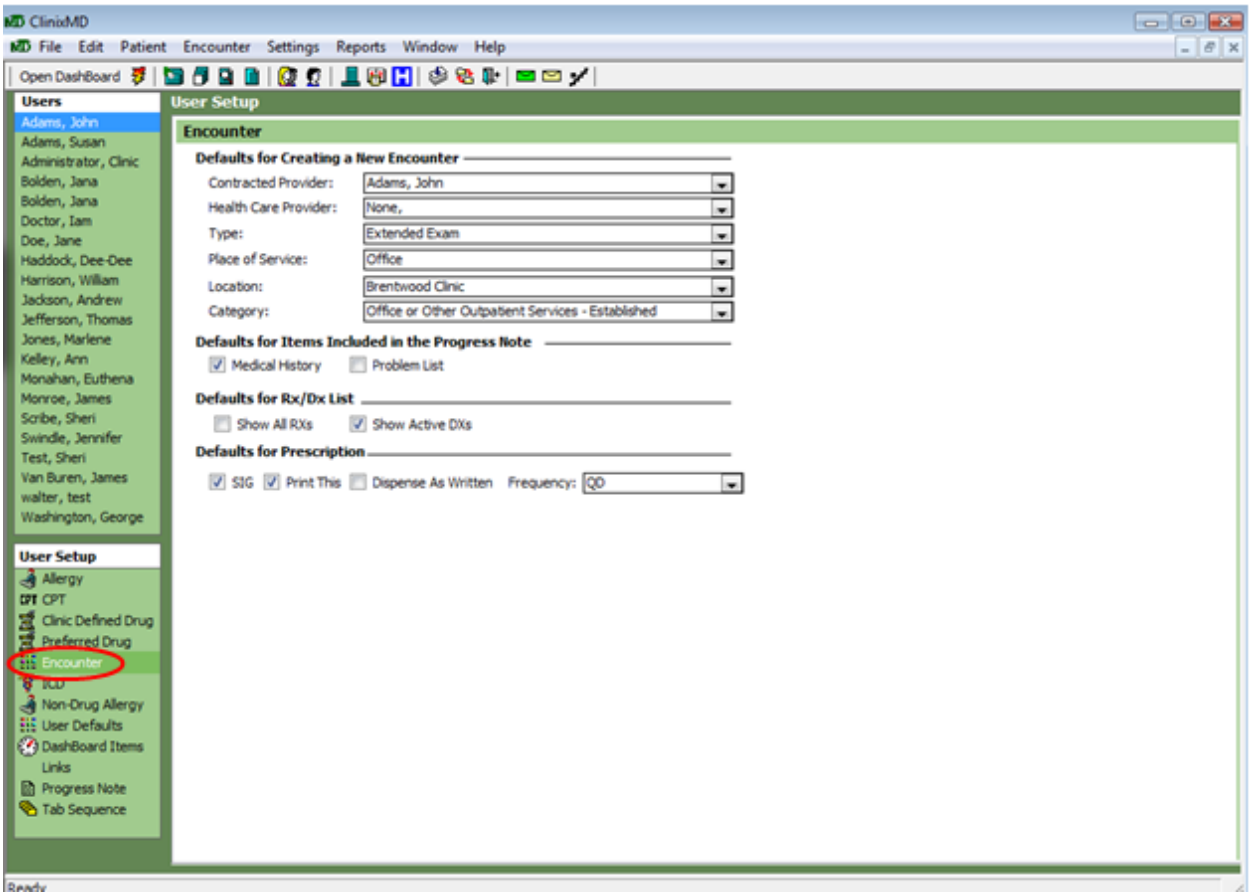
6. ENCOUNTER

The ‘Encounter’ tab allows the administrator to create a default list of choices that will be pre-filled for a specific user.



This tab contains six drop-down list boxes and default settings for the Progress Note, RX/DX List and Prescription that allow for the setting up of the following:

- Physician Name
- Health Care Provider
- Type
- Place of Service
- Location
- Category
- Defaults for Items Included in the Progress Notes
- Defaults for RX/DX List
- Defaults for Prescription

Once created the user will see these choices populated in the New Encounter window without having to use the drop-down list boxes to make these Selections. After the new encounter is saved, these same settings will also appear in the Encounter tab that is found in the Encounter window.

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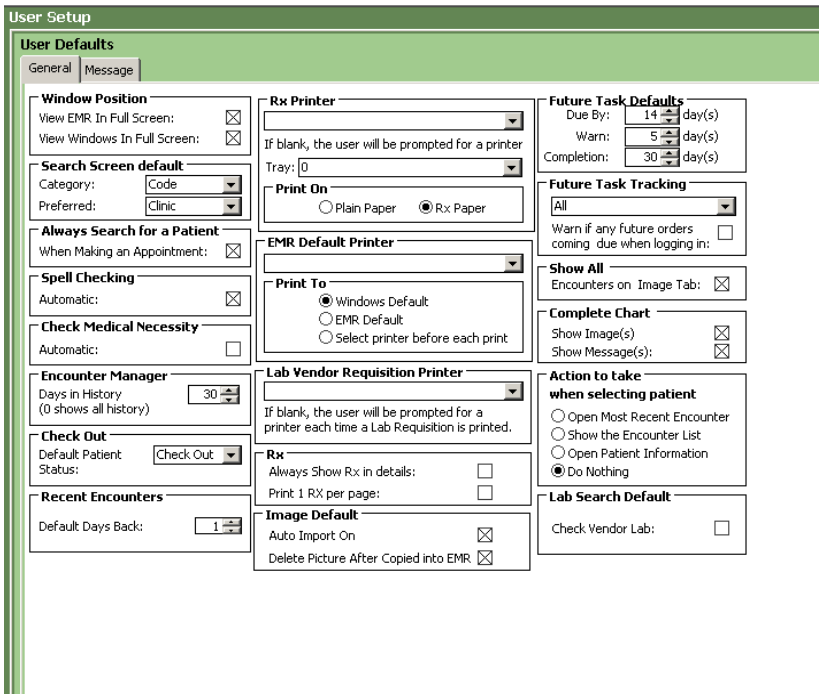
7. USER DEFAULTS

The ‘User Defaults’ tab is used to create defaults for a specific user. The administrator can customize a user’s defaults specific to each user based on their roles and responsibilities within the practice.



The ‘General’ tab consists of the following:

- **Window Position** – Sets the default on how the user will view CLINIXMD in either full screen or windows full screen.
  The most commonly used setting for viewing CLINIXMD is in full screen mode.

- **Search Screen** – Sets the default radio button in search windows.

- **Always Search for a Patient** - Setting this default will open a search window when scheduling an appointment

- **Spell Checking** – Sets the default to automatically spell check certain windows in ClinixMD

- **Check Medical Necessity-** This allows users to activate automatic medical necessity checking in the “Diagnosis” tab in encounters

- **Encounter Manager** – Sets the days in history (“0” shows all history)

- **Check Out** – Sets the default patient status

- **Recent Encounters**- Sets the default days in history for the Recent Encounter tool.

- **RX Printer** – Sets the default RX Printer. If left blank, the user will be prompted to for a printer each time they need to print an RX. The “Print On” radio button allows you to set the default paper type (a pre-defined printer in the office should contain a tray with thatch-embossed paper for printing RX’s)

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- **EMR Default Printer-** Sets the default printer.
- **Print To** - It is recommended that users who switch printer/work stations select the "Select printer before each print" option.
- **Lab Vendor Requisition Printer** – Sets the default printer for printing Lab Vendor Requisitions. If left blank, the user will be prompted for a printer each time a lab requisition is printed.
- **RX** – Sets the default to show details in the "Prescription" tab
- **Image Default-** To be used with the wireless image capture functionality. If using this feature, mark both the "Auto Import On" and the "Delete Picture After Copied into EMR" check-boxes.
- **Future Tasks Defaults** – Sets the *Completion* and *Due By* days.
- **Future Task Tracking** – Sets the default for a specific user or the entire staff to notify upon log in if any future orders are coming due.
- **Show All**- Sets the default to show images from all encounters (not just the current encounter) in the "Images" tab within an encounter
- **Complete Chart** –Gives the user the option of including images and/or messages as part of the complete chart.
- **Action to Take** – Sets the default for what action to take when selecting a patient.
- **Lab Search Default-** Allows you to set the default search list when ordering labs to "Vendor Labs" only

The 'Message' tab consists of the following:

- **Message Notifications**- Can set the notification types for normal and urgent messages
- **Auto-Archive on Reply**- Mark this box to automatically archive messages once it is replied to
- **Message Type**- Sets the default message type when composing a new message (can be changed on demand, if needed).
- **Subject-** Sets a default message subject line when composing a new message

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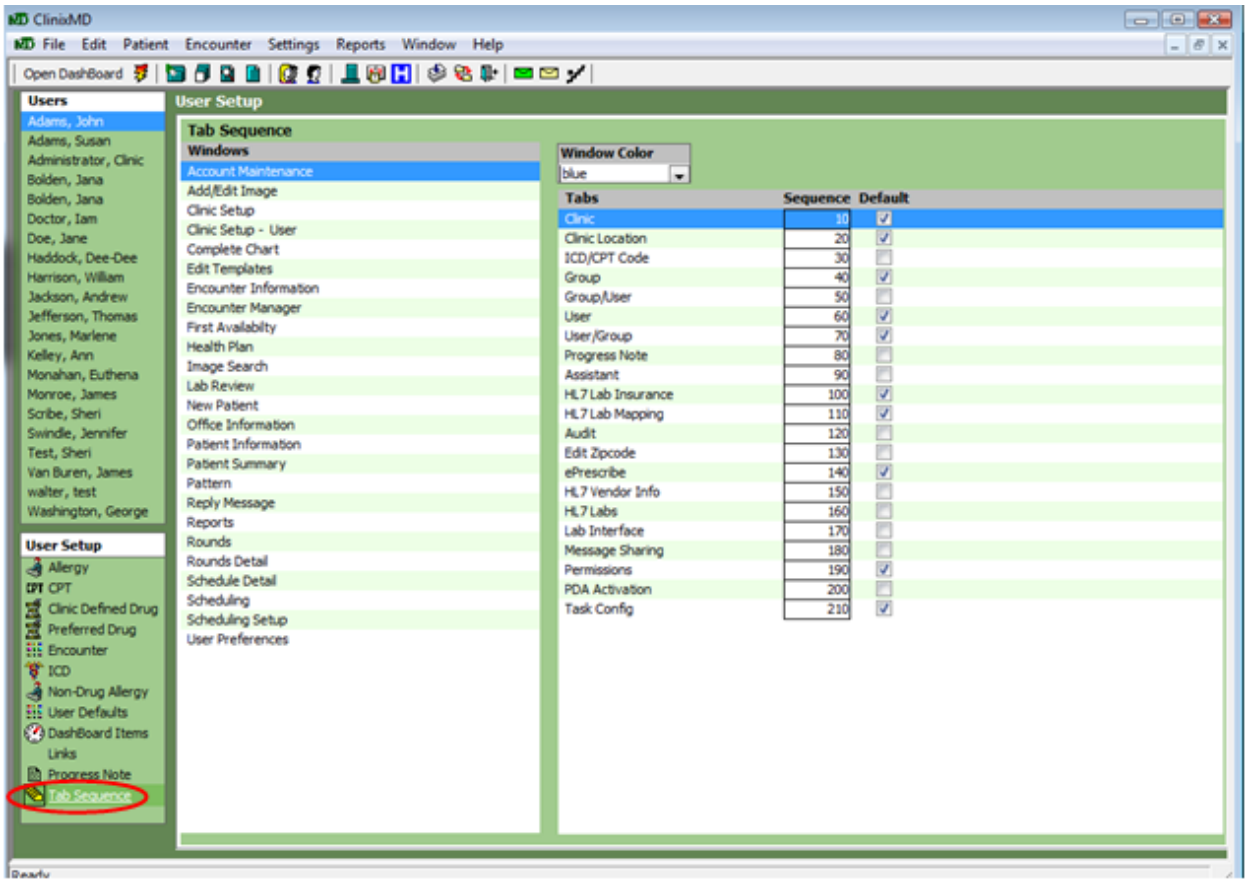
8.TAB SEQUENCE

The 'Tab Sequence' tab section is used to set defaults and sequencing for various components of the ClinixMD application. The administrator will select each window for which the user has permissions and will sequence/default the tabs accordingly. Once the administrator has defaulted tabs and sequenced this list, it will become the default list for that user



To modify the Tab Sequence tab in the ClinixMD windows, follow the steps outlined below:

a. Select *Settings->Account Maintenance->Tab Sequence.*
b. Enter a number less than 10 to place the tab you select in first position.
c. Enter a number between 10 and 20 in the tab that you want to appear in the second position.
d. Follow the same logic to arrange the remaining tabs in the order desired.
e. If the Tab will be a default for the user, place a checkmark in the default box.
f. If you would like to change the default color in any window, select a color from the "Window Color" drop-down list.

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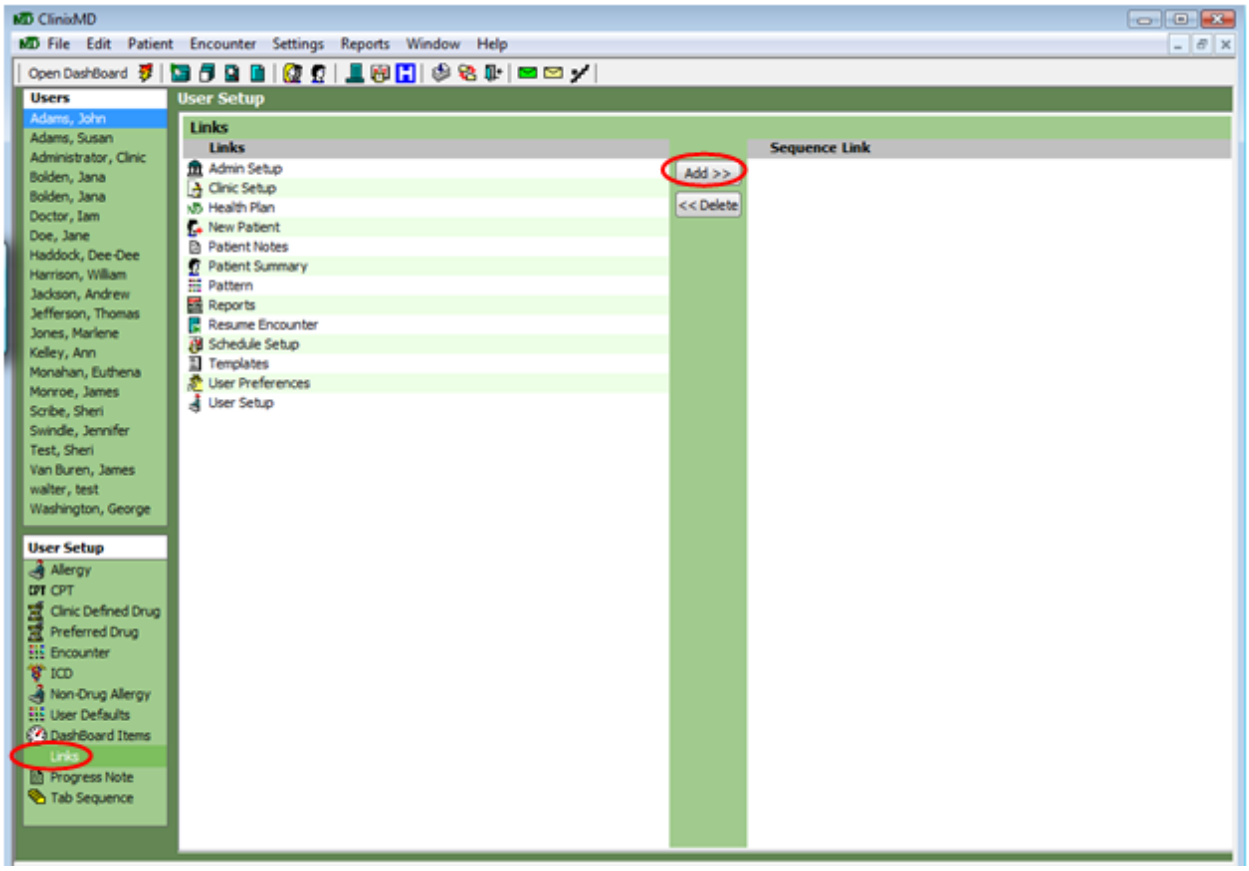
9. LINKS

The ‘Links’ tab section is used to create defaults for a specific User. The Administrator can customize a User’s defaults specific to each User based on their roles and responsibilities within the practice. The Links item will be placed on the toolbar for the User.



The Links tab consists of the following:

- Admin Setup
- Clinic Setup
- Health Plan
- New Patient
- Patient Notes
- Patient Summary
- Pattern
- Reports
- Resume Encounter
- Schedule Setup
- Templates
- User Preferences
- User Setup

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To add a Link Item to a User, follow the steps outlined below:

a. Select *Settings->User Setup->Links*
b. Highlight the Link Item to be added to the Users list and select **Add.**
c. Follow the same steps to add additional Link Items.
d. To sequence the Links on the toolbar, enter a number less than 10 to place the tab you select in first position.
e. Enter a number between 10 and 20 in the tab that you want to appear in the second position.
f. Follow the same logic to arrange the remaining tabs in the order desired.

To delete a Link, follow the steps outlined below:

a. Select *Settings->User Setup->Links*
b. Highlight the Link Item to be deleted from the Users list and select **Delete.**
c. Follow step b to delete additional Link Items.

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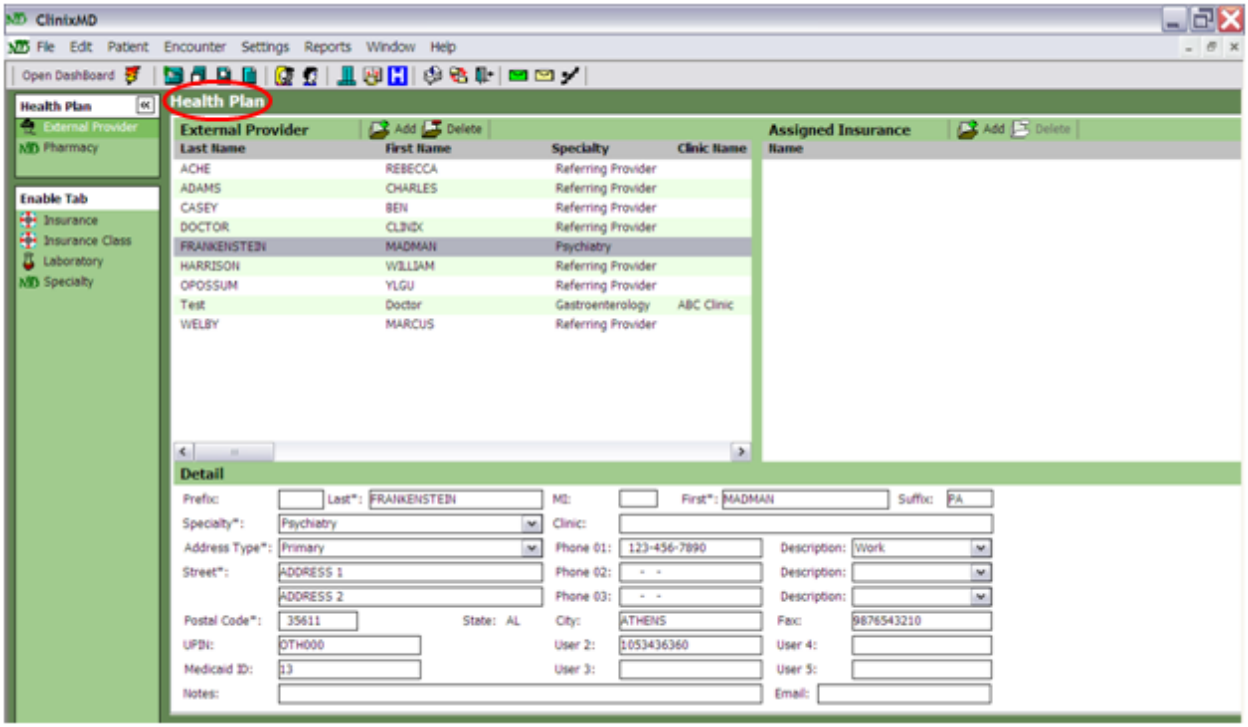
HEALTHPLAN

The ‘Health Plan’ tab is used to maintain insurance information as well as other external facilities used by the clinic.



The following tabs will be covered in this section:

1. External Provider
2. Pharmacy
3. Specialty
4. Insurance
5. Insurance Class
6. Laboratory

Once the information about these facilities is entered, it will become available to the clinic for use in referring patients to participating facilities.

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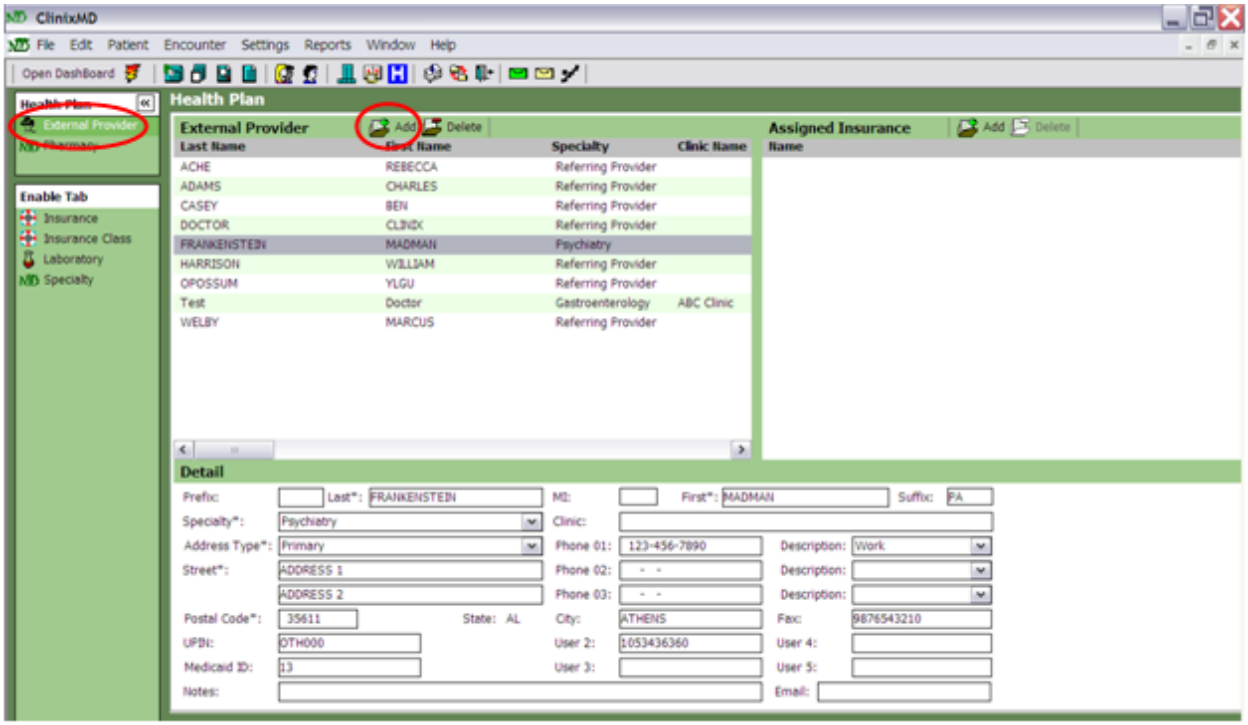
1. EXTERNAL PROVIDER

The 'External Provider' tab is used to maintain the list of physicians who see patients outside of the clinic.



These physicians are usually specialists who a referred by one of the clinic doctors. This tab is divided into three panes. The *External Provider* pane displays the list of physicians as single line items with First and Last Names. The second pane labeled *Assigned Insurance* contains all the insurance carriers attached to the External Provider. This pane displays all insurance carriers accepted by the particular physician. The third pane labeled *Details* includes a comprehensive view of the physician information and includes the following:

- **Prefix** – Used to enter the prefix for a physician.
- **Last Name** (required) – Used to enter the physician's last name.
- **Middle Initial (M.I.)** – Used to enter the physician's middle initial.
- **First Name** (required) – Used to enter the physician's first name.
- **Suffix** –Used to enter a suffix for physician.
- **Specialty** (required) – This drop-down list is available to Select the physician's specialty. Refer to the Specialty section for more on this feature.
- **Clinic Name** (required) – Used to enter the name of the clinic.
- **Address Type** (required) – This field includes a drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.

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- **Postal Code** (required) – This field is used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The user is then asked to fill in the necessary postal code information to update the database.

- **State** – This field is automatically populated based on the Postal Code entered.

- **Phone 1-3 with Descriptions** – Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.

- **Fax** – Used to enter the fax number for an external provider.

- **City** – This field is automatically populated based on the Postal Code entered.

- **Email** – Used to enter an email address for the external provider.

- **Note** – Available to add further details about the physician

To add an External Provider, follow the steps outlined below:

a. Select *Settings->Health Plan->External Provider.*
b. From the External Provider tab, click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. The fields in the *Details* pane clear allowing you to fill in the necessary information for the provider.
c. Enter information in the required fields (required fields are indicated with an asterisk (*) next to the label). The other fields are available for entering more details about the physician but are not required.

To add an Assigned Insurance, follow the steps outlined below:

a. Select *Settings>Health Plan->External Provider.*
b. From the Assigned Insurance pane, click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays in the *Assigned Insurance* pane.
c. Use the drop-down list box to select the insurance that is accepted by the external provider. (Refer to the Insurance Tab information later in this section for more on adding insurance carriers).
d. Repeat the above steps as necessary.

To delete an External Provider, follow the steps outlined below:

a. Select *Settings>Health Plan->External Provider.*
b. From the External Provider tab, Select the provider you want to delete by clicking the *External Provider Name.*
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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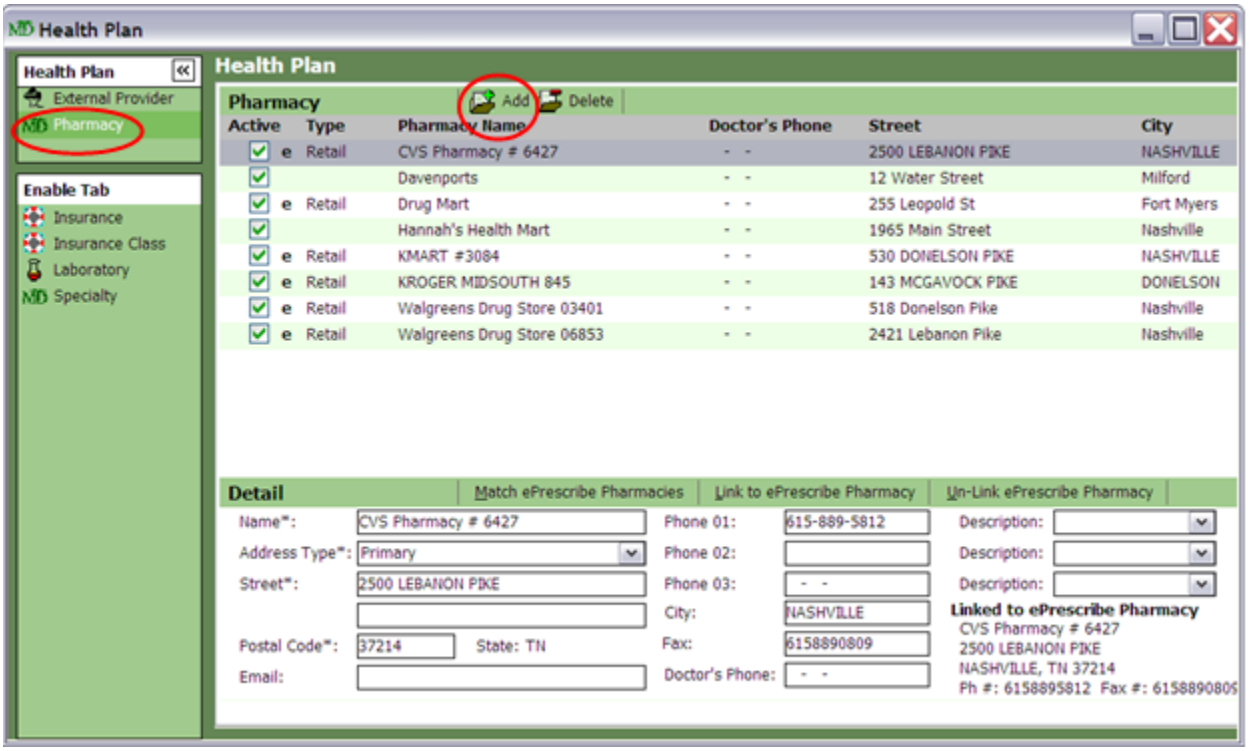
2. PHARMACY

The ‘Pharmacy’ tab contains a list of pharmacies that a clinic uses for filling prescriptions.



The tab is divided into two panes. The *List* pane displays each pharmacy as a single line item with limited information for quick viewing. The *Details* pane shows a more comprehensive view and includes the following and steps to setup the pharmacy for ePrescribe:

- **Name** (required) – Used to identify the name of the associated clinic location.
- **Address Type** (required) – A drop-down menu that offers different address types.
- **Street** (required) – Used to enter the physical address for the facility.
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized
  by the system, a dialog box will appear indicating a new zip code. The user is then asked to fill in the necessary
  postal code information to update the database.
- **State –** This field is automatically populated based on the Postal Code entered.
- **Email** – Used to enter email addresses for pharmacy locations.
- **Doctor’s Phone** – Available to include the physician phone number.

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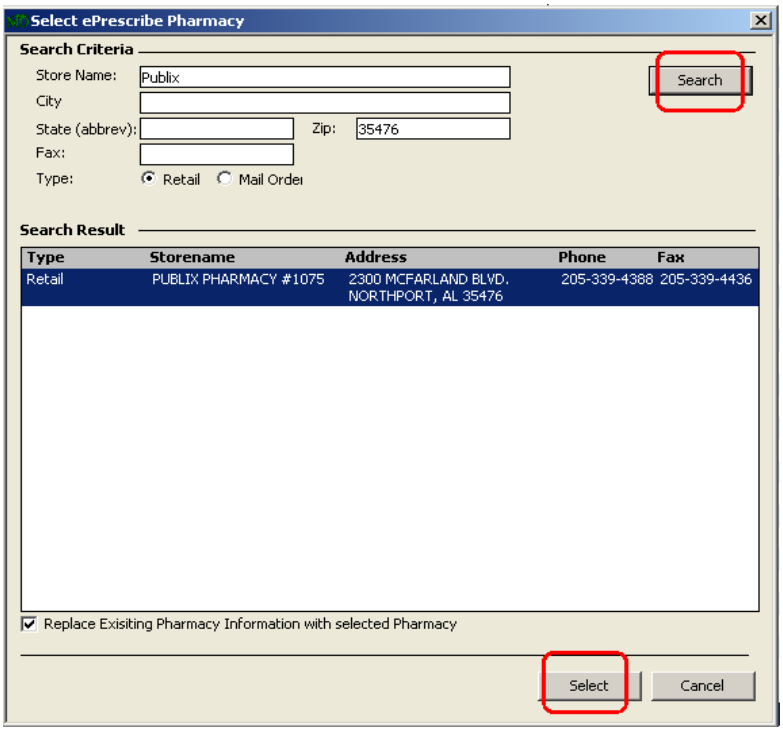
- **Phone 1-3 with Descriptions –** Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, and Pager etc.

- **City –** This field is automatically populated based on the Postal Code entered.

- **Fax –** Used to enter the fax number for a location

To add a Pharmacy, follow the steps outlined below:

a. Select *Settings->Health Plan->Pharmacy.*
b. Click the **Add** icon on the toolbar.
c. Fields marked by an asterisk (*) in the "Detail" section are mandatory and the remaining are optional.
d. To link to an ePrescribe Pharmacies, click *Link to ePrescribe Pharmacies* and the following window will appear:



e. Select the appropriate pharmacy type: Retail or Mail Order

f. Enter search criteria (i.e. zip code only or part of pharmacy name and zip code) and then click **Search**.
g. A list of all pharmacies matching the search criteria will be displayed under **Search Result**.
h. Highlight the pharmacy from the search results that you want to link to and choose **Select.**
i. **To replace an existing pharmacy's information: Highlight the selection and place a checkmark in the "Replace Existing Pharmacy Information with Selected Pharmacy".

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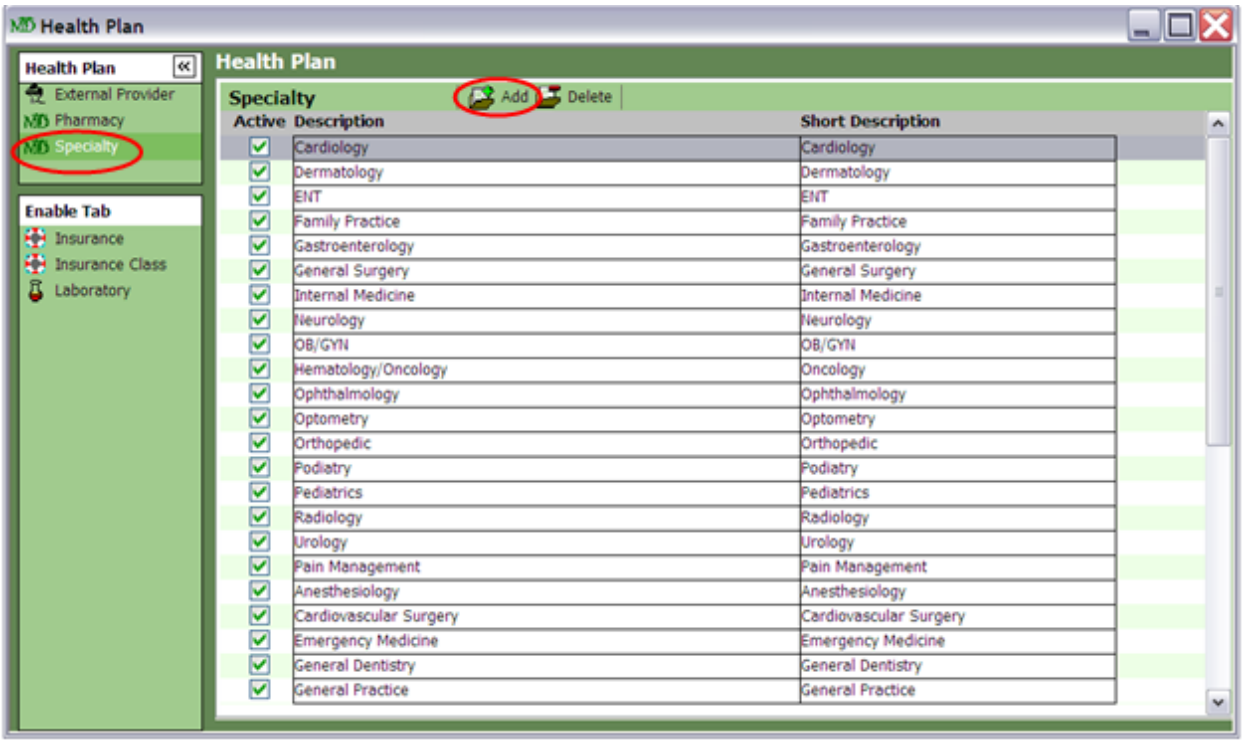
3. SPECIALTY

The 'Specialty' Tab is used to maintain a list of Specialties for the External Providers.



The tab contains two columns. The first allows for a *Description* to be entered describing the specialty. The second column is an optional text field for entering a *Short Description*. This short description is primarily important to PDA (Personal Digital Assistant) users. The short description is used on these devices to save screen space.

To add a Specialty, follow the steps outlined below:

a. Select *Settings>Health Plan->Specialty.*
b. Click the "**Add**" button on the toolbar or right-mouse click and select "**Add**" from the drop-down menu. A new row appears in the Specialty tab.
c. Type in the description in the *Description* column and a *Short Description* in the second column (short description is optional and used for PDA devices).

To delete a Specialty, follow the steps outlined below:

a. Select *Settings>Health Plan->Specialty.*
b. Select the specialty you want to delete from the list
c. Click the "**Delete**" button on the toolbar or right-mouse click and select "**Delete**" from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking *OK.*

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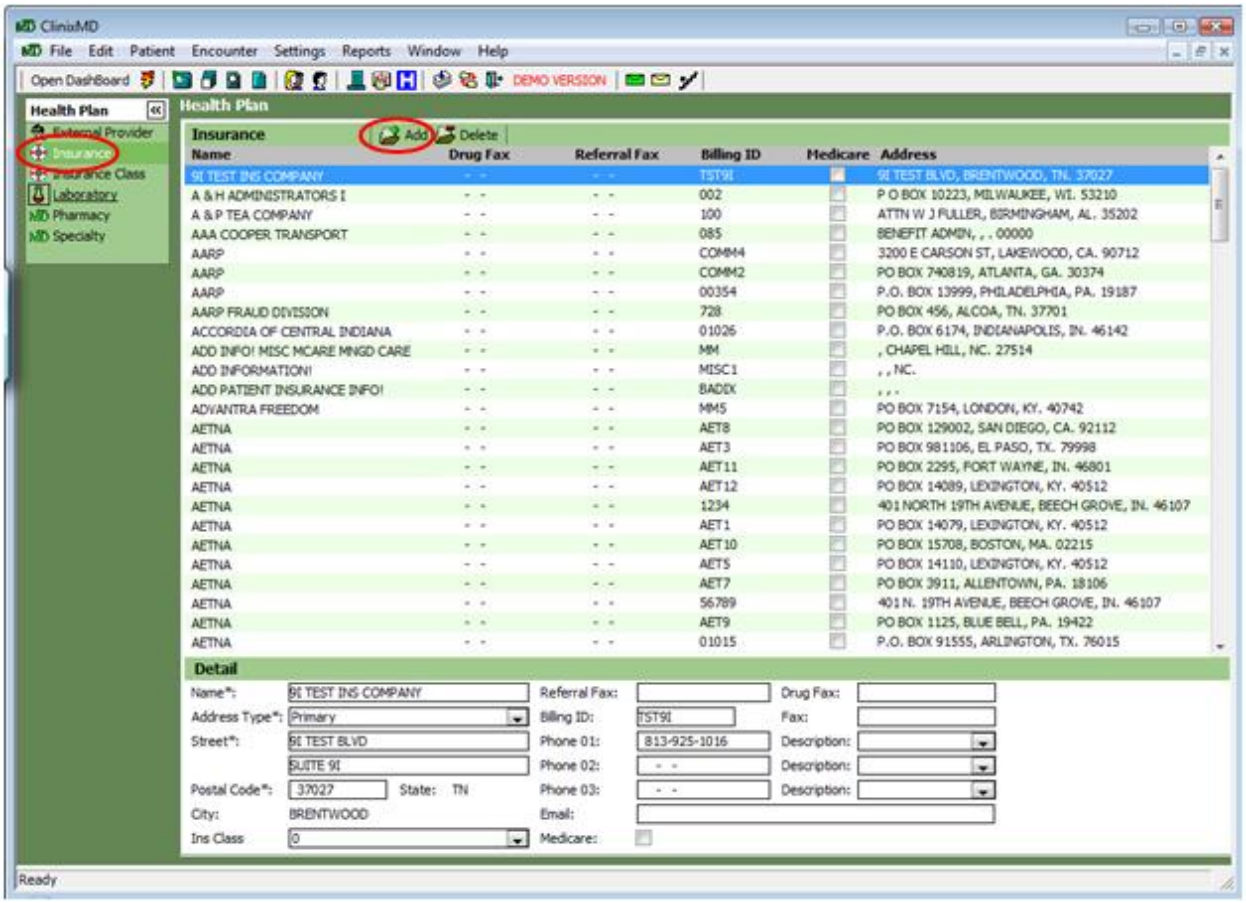
4. INSURANCE

The 'Insurance tab' is used to maintain a list of carriers that are accepted by the clinic. Once the Administrator creates the list, it is then available to the office staff when entering insurance information for a patient. Note: This information will cross over the scheduling/demographics interface from your Practice Management system. In this case, this list will need to be maintained in that system.



The Insurance information is organized with the following:

- Name
- Address Type
- Street
- Postal Code
- Ins Class
- Referral Fax
- Drug Fax
- Billing ID
- Fax
- Phone 1-3
- Email
- Medicare (must be marked in order for the "Automatic G-Code Population" feature to work in Settings→Account Maintenance→Clinic Location→RX Options)

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To add an Insurance Carrier, follow the steps outlined below:

a. Select *Settings->Health Plan->Insurance.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays in the Insurance tab.
c. Enter the Name, Address, Postal Code, Ins Class, Referral Fax, Billing ID, Phone 1-3 (if applicable), Email (if applicable), Drug Fax, Fax, and Phone Description (if applicable using drop-down boxes) and whether carrier is Medicare.

To delete an Insurance Carrier, follow the steps outlined below:

a. Select *Settings->Health Plan->Insurance.*
b. Click the Insurance Carrier you want to delete.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK

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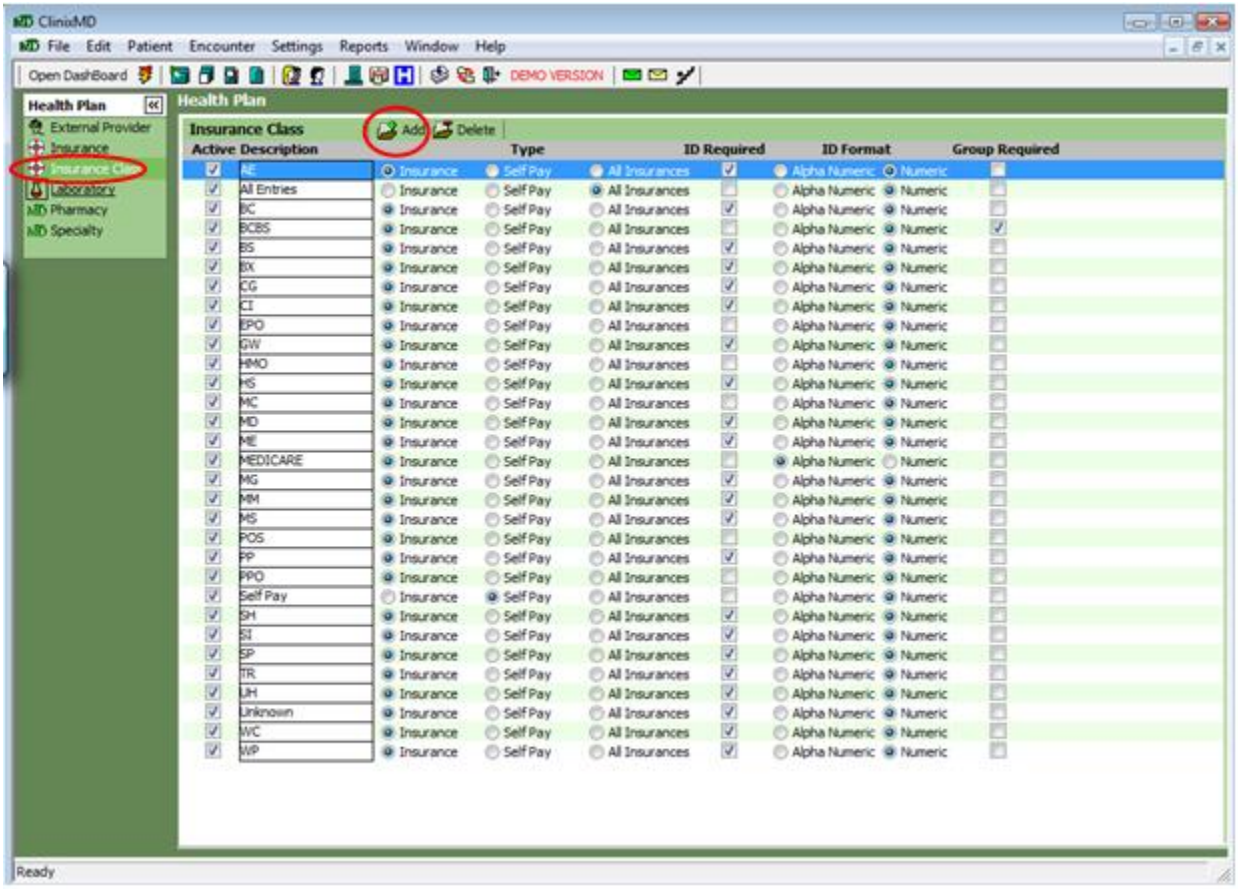
5. INSURANCE CLASS

The 'Insurance Class' tab is used to maintain the list of classes of insurance carriers that are accepted by the clinic. Once the Administrator creates the list, it is available to the office staff when entering insurance information for a patient.



The Insurance information is organized with the following:

- Description
- Type
- ID Required
- ID Format
- Group Required

To add an Insurance Class, follow the steps outlined below:

a. Select *Settings->Health Plan->Insurance Class.*
b. Click the **Add** icon on the toolbar or right-mouse click and select **Add** from the drop-down menu. A new row displays in the Insurance tab.
c. Enter the Description; select Type, select radio button if an ID is required, select ID Format Type and if Group is required.

To delete an Insurance Carrier Class, follow the steps outlined below:

a. Select Settings->Health Plan->Insurance Class.
b. Click the Insurance Class you want to delete.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK.

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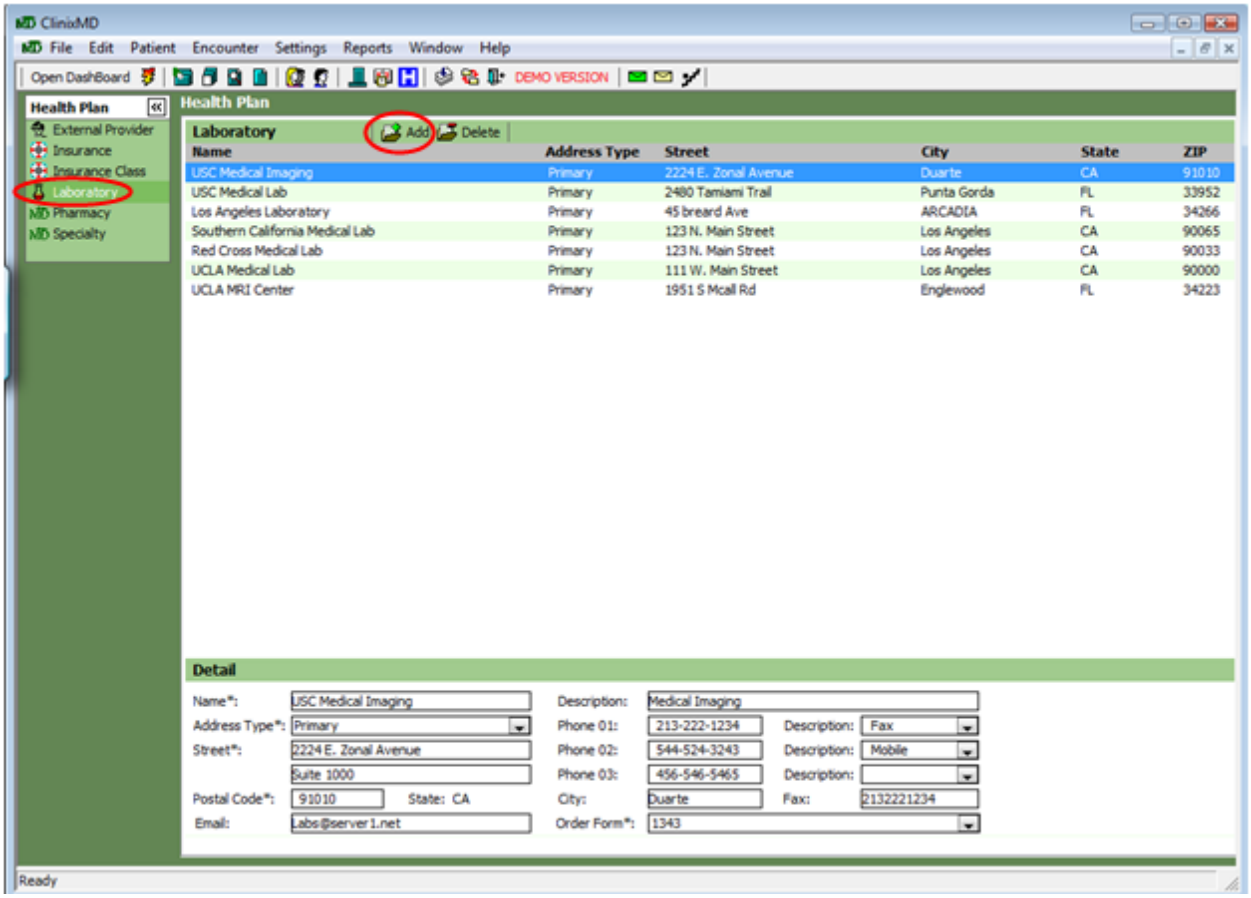
6. LABORATORY

The 'Laboratory' tab is used to maintain a list of facilities that perform testing for and are connected to the clinic. This window is divided into two panes. The *List* pane displays a single-line item view of the laboratories used by the clinic.



The lower *Detail* pane displays a more comprehensive view and includes the following:

- **Name** (required) – Used to identify the name of the associated laboratory location
- **Description** – Available to add further details about the laboratory
- **Address Type** (required) – A drop-down menu that offers different address Types
- **Street** (required) – Used to enter the physical address for the facility
- **Postal Code** (required) – Used for entering the Postal or Zip Code of the facility. If the zip code is not recognized by the system, a dialog box will appear indicating a new zip code. The User is then asked to fill in the necessary postal code information to update the database.
- **State –** This field is automatically populated based on the Postal Code entered
- **Email** – Used to enter email addresses for laboratories

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- **Phone 1-3 with Descriptions –** Available to add phone numbers for the location. Each phone number has a corresponding drop-down description box to identify the type of phone number, i.e. Home, Office, Pager etc.
- **City –** This field is automatically populated based on the Postal Code entered
- **Fax –** Used to enter the fax number for a laboratory
- **Order Form** (required) **–** This drop-down list box is used to select the order form that is attached to this laboratory.

To add a Laboratory, follow the steps outlined below:

a. Select *Settings>Health Plan->Laboratory.*
b. Click the **Add** button on the toolbar or right-mouse click and select **Add** from the drop-down menu. Fill in the information in the Detail pane for the laboratory.

To delete a Laboratory, follow the steps outlined below:

a. Select *Settings>Health Plan->Laboratory.*
b. Click the Laboratory you want to delete from the List Pane.
c. Click the **Delete** icon on the toolbar or right-mouse click and select **Delete** from the drop-down menu. A confirmation dialog box displays.
d. Confirm your deletion by clicking OK.

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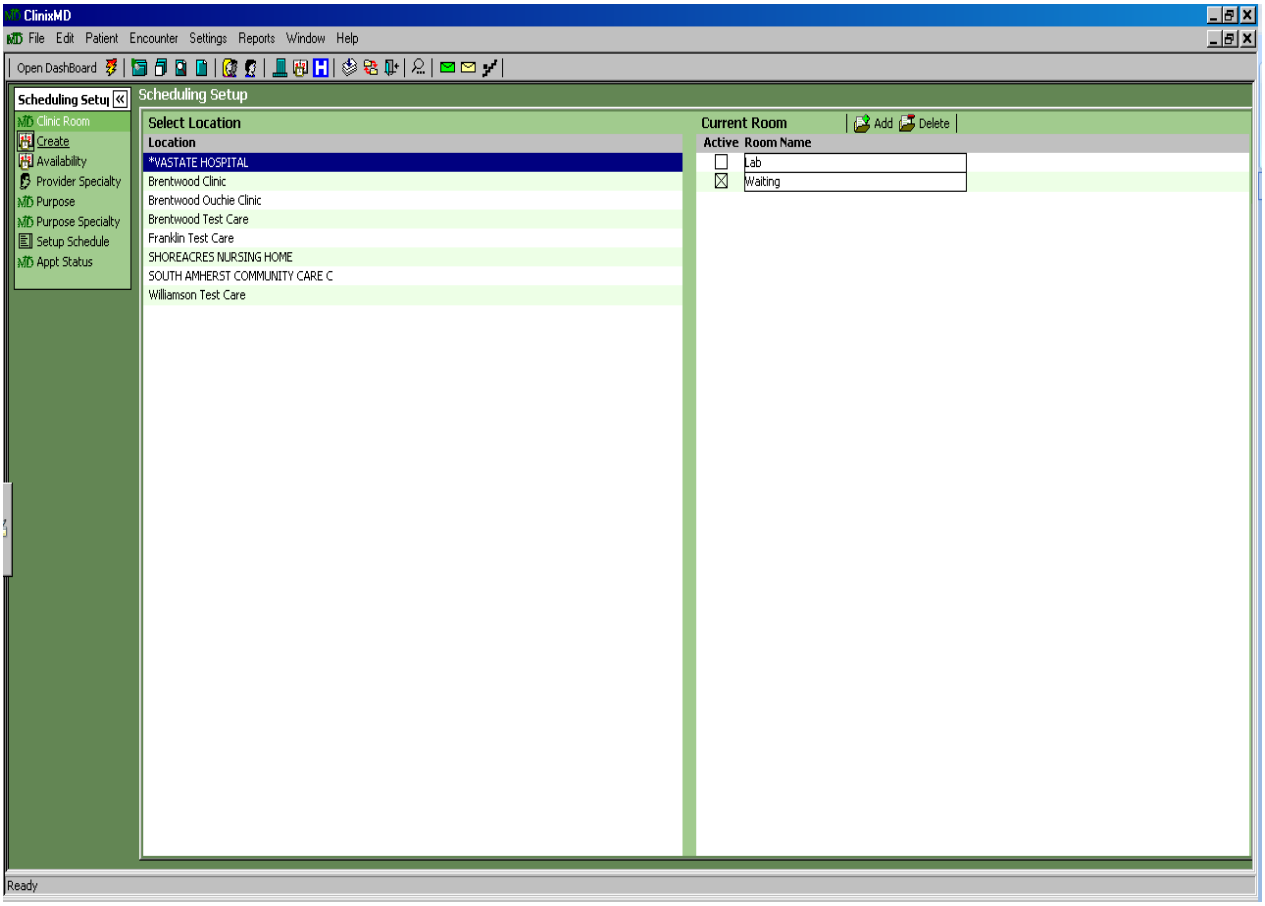
SCHEDULING SET UP

The Scheduling Setup area houses necessary information related to scheduling in ClinixMD. If your clinic uses a PM system, the schedule flows into ClinixMD via an interface into the Patient Locator (located in the 'Office' area). However, you will need to enter specific information in ClinixMD in order for it to populate in the Patient Locator, including Clinic Room names and Provider Specialty.



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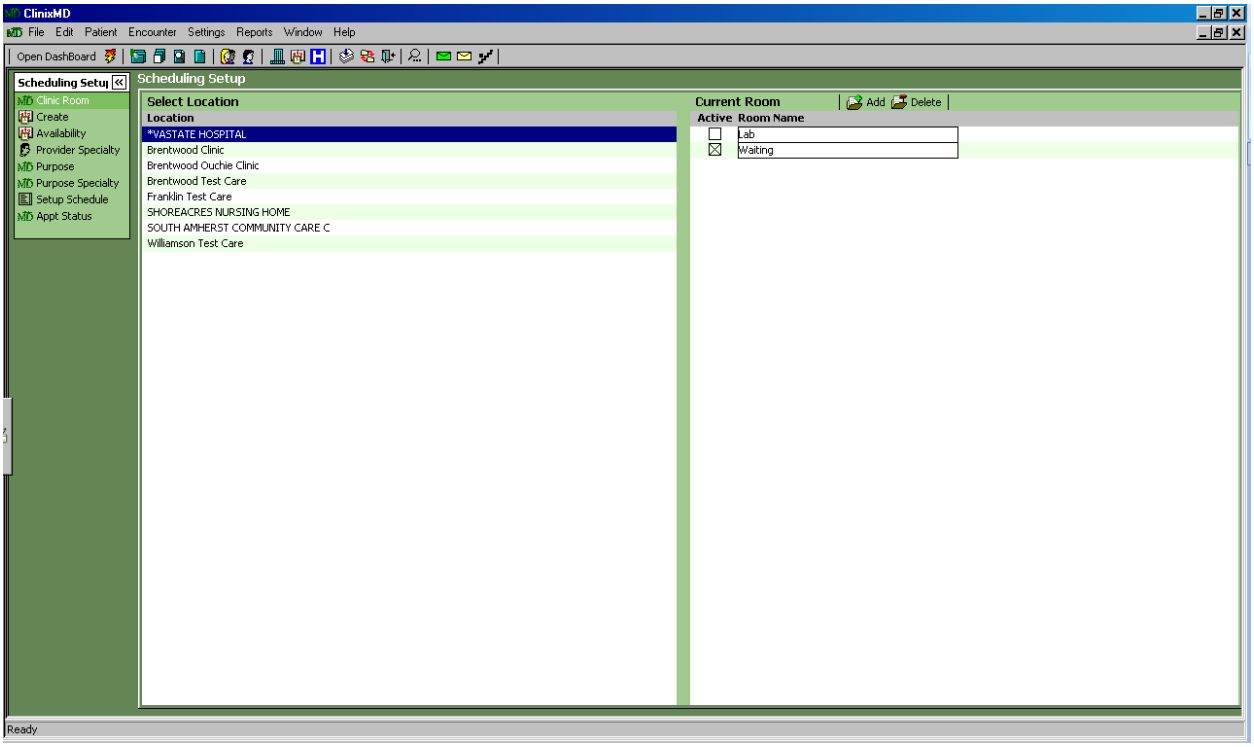
1. CLINIC ROOM

The 'Clinic Room' tab is where you establish the names of rooms in ClinixMD that your clinic currently utilizes (i.e. Waiting Room, Exam Room 1, Lab, Diagnostic Waiting Room, etc.). This list is available in the Patient Locator and is used to keep track of your patients' locations within the system.



To add Clinic Room names, follow the instructions outlined below:

a. Select *Settings→Scheduling Setup→Clinic Room*
b. Select the desired location.
c. In the *Current Room* pane, click the "**Add"** button.
d. Type in the desired room name in the free-text field.
e. Mark the room as **Active**.
f. To inactivate a room, remove the mark from the **Active** checkbox. To delete a room name that is not in use, click the **Delete** button.

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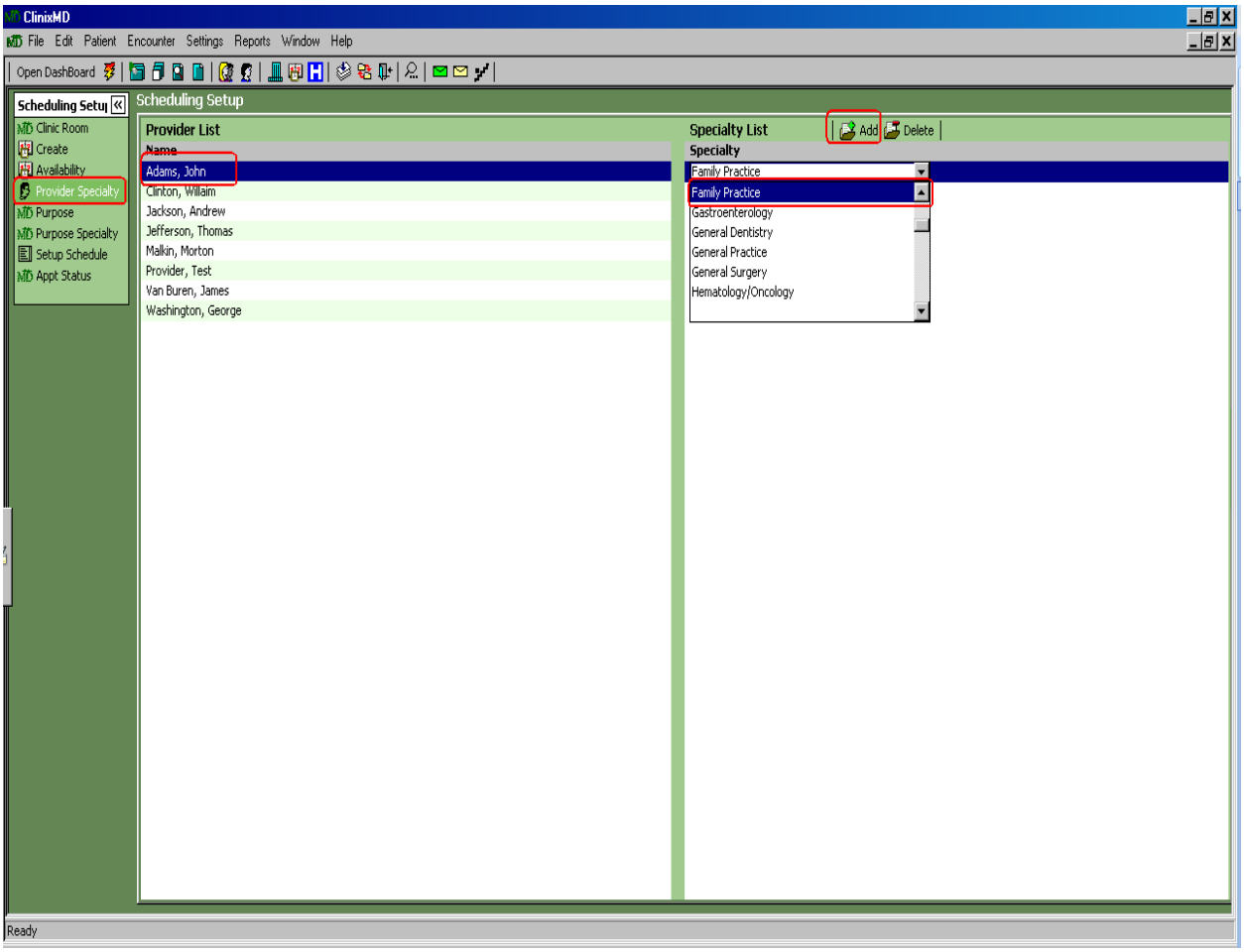
2. PROVIDER SPECIALTY

The 'Provider Specialty' tab is used to assign a providers specialty so the provider's schedule will populate from the interface into the Patient Locator.



To add a specialty to a provider, follow the instructions outlined below:

a. Select *Settings→Scheduling Setup→Provider Specialty*
b. Select the appropriate user from the **Provider List** pane.
c. Click the "**Add"** button located to the right of **Specialty List**.
d. Select the desired specialty from the drop-down list.

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